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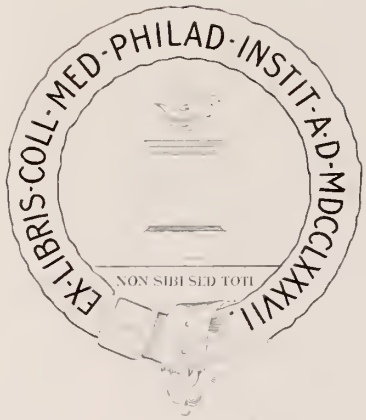

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the wisconsin medical journal

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Membership roster, services and structure of the State Medical Society of Wisconsin.

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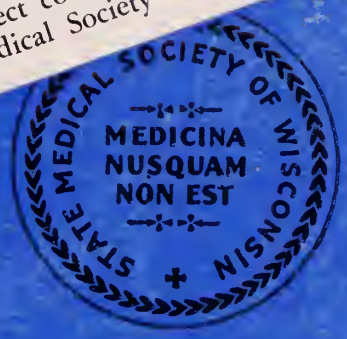

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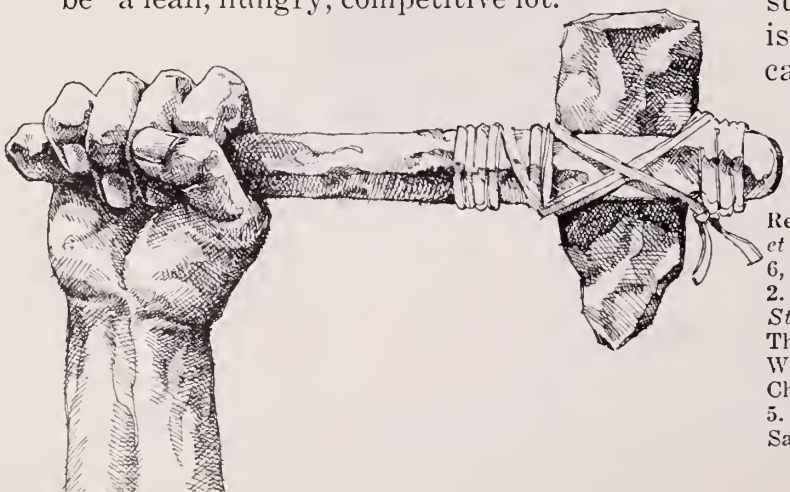
IF MORE MEN CRIED

At least seventy-five out of one hundred adults with duodenal ulcers are men.[1] Why? It may be significant that duodenal ulcer patients tend to crave recognition and are "especially vulnerable to threats to their manly assertive independence."[2]

Hypersecretion—an atavistic response. Stewart Wolf, who, with Harold G. Wolff, studied the personalities of duodenal ulcer patients, wonders if masculine competitiveness is related to "an atavistic urge to devour an adversary." It is striking, he reports, that an accentuation of gastric acid secretion and motility can be "induced in ulcer patients by discussions that arouse feelings of inadequacy, frustration and resentment."[2]

By chance? A lean, hungry lot. Was the link between emotions and gastric hyperacidity acquired through mutation to serve a purpose? During man's jungle period of evolution, the investigator points out, a male dealt with a foe by killing and devouring it. "It may be more than coincidence," he concludes, that peptic ulcer patients appear to be "a lean, hungry, competitive lot."[3]



Big boys don't cry. If more men crie maybe fewer would wind up with duoden ulcers. But men will be men—the sum total their genes and what th are taught. Schottstae observes that when mother admonishes h son who has hurt himse that big boys don't cry, s is teaching hi stoicism.[4] Crying is t negation of everythi society thinks of as manl A boy starts defending h manhood at an early ag

Take away stres you can take away symptom

There is no question that stress plays role in the etiology of duodenal ulce Alvarez[5] observes that many a man with a ulcer loses his symptoms the day he shuts u the office and starts out on a vacation. T problem is, the type of man likely to have a ulcer is the type least likely to take lon vacations or take it easy at work.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1972 WISCONSIN

Feb. 17: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Immediate Care of Acute Stroke" and "Current Management of Diabetic Keto-acidosis and Coma," at St. Marys Hospital Medical Center, Madison.

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Mar. 15: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Current Management of Rh ve Pregnant Patient Before and After Delivery" and "Current Management of the Newborn Who Becomes Jaundiced in the First 24 Hours," at St. Marys Hospital Medical Center, Madison.

Mar. 23–25: *Learning Disabilities in Children,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Mar. 31–Apr. 1: Midwest Chapter, College of Sports Medicine Meeting, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 13–15: *Advances in Pediatric Radiology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Applied Genetics for the Clinician Conference, Wisconsin Center, Madison. Info: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

1972 NEIGHBORING STATES

Feb. 15–18: Four-day refresher course for family practitioner of medicine, University of Iowa Health Center. Info: Director, Office of Medical Education, Office of the Dean, University of Iowa, Iowa City, Iowa 52240.

Mar. 16–17: Female Reproductive Physiology Symposium, Rockford Memorial Hospital, Rockford, Ill. Info: Dr. Ronald Burmeister, 2300 North Rockton Ave., Rockford, Ill. 61103.

Apr. 17–19: 2nd Annual Great Lakes Health Congress—Health Industries Association, Mid-America Assembly, and Tri-State Hospital Assembly. McCormick Place-on-the-Lake, Chicago, Ill. Info: Great Lakes Health Congress, 400 North Michigan Avenue, Chicago, Ill. 60611. (Phone: 312/321–0317)

1972 AMA

Mar. 16–17: 25th National Conference on Rural Health, AMA Council on Rural Health, St. Francis Hotel, San Francisco, Calif.

Mar. 22–25: National Congress on the Quality of Life, AMA Board of Trustees in cooperation with 20 governmental and volunteer agencies, Palmer House Hotel, Chicago, Ill.

Apr. 6–8: Sixth National Congress on the Socio-Economics of Health Care, Ft. Lauderdale, Fla.

Apr. 24–25: Congress on Environmental Health, The Biltmore Hotel, Los Angeles, Calif.

June 18–22: Woman's Auxiliary 50th Anniversary Convention, St. Francis Hotel, San Francisco, Calif.

June 18–22: AMA Annual Meeting, St. Francis Hotel, San Francisco, Calif.

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Mar. 1–4: *Medical Malpractice: A Legal Course for Doctors,* Americana Hotel, Bal Harbour, Fla. Info: IV Medical/Legal Institute, University of Miami Law Center, Coral Gables, Fla. 33124.

Apr. 10–11: Cancer Seminar, American Cancer Society, Flamingo Hotel, Las Vegas, Nev. Info: Sol T. DeLee, MD, Chairman, Cancer Seminar, 301 South Highland Drive, Las Vegas, Nev. 89106.

Mar. 15–18: 17th Annual Central Florida Medical Meeting, Contemporary Hotel, Walt Disney World, Orlando, Fla. Info: Franklin G. Norris, MD, Program Chairman, Orange County Medical Society, 800 N. Mills Ave., Orlando, Fla. 32803. (Phone: 241–3338)

Apr. 17–20: American Industrial Health Conference, American Industrial Medical Association and American Association of Industrial Nurses, Philadelphia, Pa. Info: Amer. Ind. Health Conf., 150 North Wacker Drive, Chicago, Ill. 60606.

April 21: Symposium on Infectious Diseases, American Academy of Family Physicians, Battenfeld Auditorium, Kansas City, Kan.

May 1–3: 19th Annual Meeting, American College of Sports Medicine, Philadelphia, Pa. Info: Donald E. Herrmann, Exec. Secy., ACSM, 1440 Monroe St., Madison, Wis. 53706.

May 12–13: Clinical–Professional Meeting, American College of Legal Medicine, Americana Hotel, Miami Beach, Fla. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

Sept. 25–28: Annual scientific assembly, American Academy of Family Physicians, New York Coliseum, New York, N.Y.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Baltimore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New Yory, N. Y., 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1974 INTERNATIONAL

Oct. 20–26: XIth International Cancer Congress, Florence, Italy.

For listing of other meetings see the **Journal of the American Medical Association.**

Congress on Quality of Life—Chicago

The AMA Board of Trustees is sponsoring, in cooperation with 20 governmental and volunteer agencies, a National Congress on the Quality of Life, March 22–25, at the Palmer House in Chicago.

The Congress will focus on the immutable concerns of the quality of life by concentrating on the first stages of life's continuum—maternal and child health from conception through adolescence and young adulthood.

Examining the growth process in terms of human development and human environment, the Congress will address itself to the problems of maternity and the newborn, children in a changing society, and the critical years of adolescence.

The program features formal presentations by experts in the medical, social and behavioral sciences, education, law, religion, and governmental affairs. Complementing their presentations will be workshops and youth, consumer, and professional reactor panels.

Major emphasis will be on developing new programs that will contribute to the richness and depth of life . . . programs sensitive to the physical, psychological, emotional, and social needs of people . . . programs reflecting a trend toward more multidisciplinary cooperation.

The AMA is hopeful that medicine will be well represented at this multidisciplinary session, since medicine holds the key to the solution of many of the problems to be discussed.

Request for program to: Effie O. Ellis, MD, AMA, 535 North Dearborn St., Chicago, Ill. 60610.

Wisconsin Diabetes Association—Milwaukee

The Wisconsin Diabetes Association will sponsor a banquet meeting on March 22, 1972, at the Northwestern Mutual Life Insurance Company, 731 North Jackson Street, Milwaukee, Wisconsin. Dr. Albert Winegrad, Professor of Medicine and Director of the George S. Cox Medical Research Institute, University of Pennsylvania, will speak on "Hyperglycemia and the Complications of Diabetes Mellitus." Further information may be obtained from the Wisconsin Diabetes Association, 225 East Michigan Street, Milwaukee, Wisconsin.

Chicago–Illinois Medical Meeting

For the first time in their history the Chicago Medical Society and the Illinois State Medical Society have merged their annual meetings into one meeting to be held at the Conrad Hilton Hotel, March 7–11. Details of the meeting appear in an ad 9A of this issue.

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WISCONSIN MEDICAL JOURNAL
Vol. 71, No. 1 JANUARY 1972

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

SMS Offers Checklist for Contacting Legislators

Mail to a modern-day legislator is more important than ever before. In the day of Clay, Calhoun, Webster, and Lincoln legislators lived among their people for perhaps nine months of the year. Today, with the staggering problems of government and increasingly long sessions, legislators may spend more than nine months a year away from home. Thus their mailbag is their best "hot line" to the grass roots.

Here are some suggestions for letters to lawmakers:

***Proper address.** All U.S. and state legislators are addressed "Honorable" followed by the full name and the office number, if known. Zip codes in Washington, D.C., are: U.S. Senators, 20510; U.S. Representatives, 20515. Letters to all state legislators can be sent to the State Capitol, Madison 53702. Address U.S. and state senators "Dear Senator"; address U.S. representatives and state representatives "Dear Mr."

***Identify the bill or issue.** If you don't know the bill number, describe it by popular title ("truth in lending," "minimum wage," etc.)

***Be timely.** Get your letter written before action has been taken on the bill (while it is still in committee or before it has come to a vote).

***Concentrate on your own delegation.** All letters written by residents of one district to other legislators are usually referred to the letter writer's representative for reply.

***Be reasonably brief.** Legislators must answer hundreds of pieces of mail each week as well as study legislation, attend committee meetings and participate in floor action. Your opinions and arguments stand a better chance of being read if they are stated as concisely as the subject matter will permit.

This Is the Way

***Write your own views—not someone else's.** A personal letter is far better than a form letter or signature on a petition. Legislators often don't know of individual experiences and observations.

***Give your reasons for taking a stand.** Congressmen may not know all the effects a bill might have.

***Be constructive.** If a bill deals with a problem you admit exists, but you believe the bill is the wrong approach, tell your legislator what the **right** approach is.

***Offer expert knowledge.** Opinions are important and will be heeded, but the advice and counsel of those who are experts are particularly valued by legislators.

***Say "well done" when it's deserved.** Legislators are human and appreciate an occasional sincere compliment.

CHECK THE FOLLOWING PAGES FOR

1971 WISCONSIN LEGISLATURE

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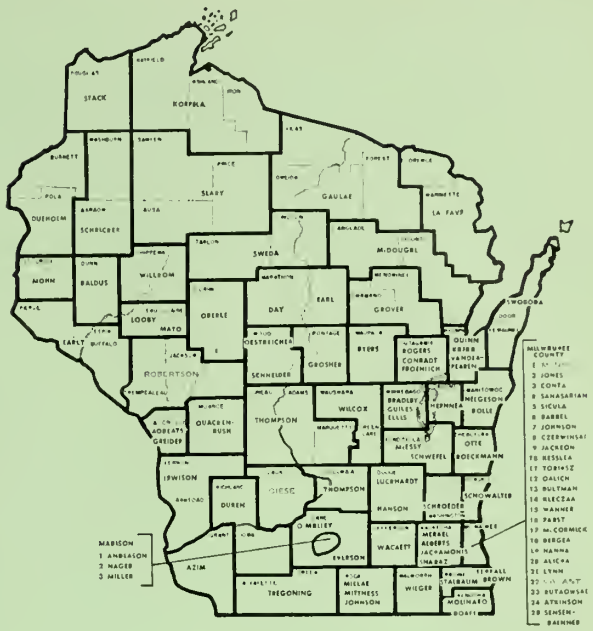
2.	Lotto, Myron P. (R)	1st, 2nd assembly districts, Brown; Calumet	37 S	R. 1, Green Bay 54301
3.	Kendziorski, Casimir (D)	11th, 12th, 14th assembly districts, Milwaukee	419 SW	2027 South 14th St., Milwaukee 53204
4.	Soik, Nile (R)	3rd, 18th, 25th assembly districts, Milwaukee	40B S	6266 N. Santa Monica Blvd., Whitefish Bay 53217
5.	Schuele, Wilfred (D)	2nd, 9th, 15th assembly districts, Milwaukee	419 SW	3036 N. 84th St., Milwaukee 53222
6.	Lipscomb, Mark G., Jr. (D)	1st, 5th, 7th assembly districts, Milwaukee	411 S	5349 N. Dexter Ave., Milwaukee 53209
7.	Frank, Kurt A. (D)	17th, 19th, 24th assembly districts, Milwaukee	------	933 E. Ohio Ave., Milwaukee 53207
8.	Busby, Allen J. (R)	20th, 21st, 22nd assembly districts, Milwaukee	329 S	1673 S. 53rd St., Milwaukee 53214
9.	Parys, Ronald G. (D)	4th, 6th, 13th assembly districts, Milwaukee	7 E	1221 E. Clarke St., Milwaukee 53212
10.	Knowles, Robert P. (R)	Buffalo, Pepin, Pierce, Burnett, Polk, St. Croix	238 S	335 E. First St., New Richmond 54017
11.	Whittow, Wayne F. (D)	8th, 10th, 16th assembly districts, Milwaukee	140A S	4921 W. Washington Blvd., Milwaukee 53208
12.	Krueger, Clifford W. (R)	Clark, Forest, Oneida, Vilas, Lincoln, Taylor	310 S	112 N. State St., Merrill 54452
13.	McKenna, Dale T. (D)	1st assembly district, Dodge; Jefferson, Washington	408 S	336 E. North St., Jefferson 53549
14.	Lorge, Gerald D. (R)	Outagamie, Waupaca	337 S	R. 1, Box 147, Bear Creek 54922
15.	Swan, James D. (R)	1st, 3rd assembly districts, Rock; Walworth	136 S	R. 2, Elkhorn 53121
16.	Thompson, Carl W. (D)	4th, 5th assembly districts, Dane; 2nd assembly district, Rock	415 S	Box 227, Stoughton 53589
17.	Roseleip, Gordon W. (R)	Grant, Green, Iowa, Lafayette, Richland	325 S	Box 167, Darlington 53530
18.	Hollander, Walter G. (R)	2nd assembly district, Dodge; Fond du Lac	114 S	R. 1, Rosendale 54974
19.	Steinhilber, Jack D. (R)	Winnebago	32A S	1748 Southland Ave., Oshkosh 54901
20.	Keppler, Ernest C. (R)	Ozaukee, Sheboygan	316 S	909 New York Ave., Sheboygan 53081
21.	Dorman, Henry (D)	1st, 2nd assembly districts, Racine	419 S	220 Ninth St., Racine 53403
22.	Lourigan, Joseph (D)	Kenosha	410 S	3604 19th Ave., Kenosha 53140
23.	Peloquin, Bruce S. (D)	Barron, Chippewa, Dunn, Washburn	9 E	R. 5, Box 357, Chippewa Falls 54729
24.	Heinzen, Raymond F. (R)	Green Lake, Waushara, Portage, Wood	312A S	R. 5, Marshfield 54449
25.	Cirilli, Arthur A. (R)	Ashland, Bayfield, Douglas, Iron, Price, Rusk, Sawyer	35 S	1511 Tower Ave., Superior 54880
26.	Risser, Fred A. (D)	1st, 2nd, 3rd assembly districts, Dane	140 S	140 W. Wilson St., Madison 53703
27.	Bidwell, Everett V. (R)	Adams, Columbia, Juneau, Marquette, Sauk	135 S	Box 183, Portage 53901
28.	Devitt, James C. (R)	23rd assembly district, Milwaukee; 3rd assembly district, Racine; 4th assembly district, Waukesha	415 SE	5151 S. Root River Pkwy., Greenfield 53228
29.	Chilsen, Walter John (R)	Marathon, Menominee, Shawano	207 S	1821 Town Line Rd., Wausau 54401
30.	LaFave, Reuben (R)	3rd assembly district, Brown; Florence, Marinette, Langlade, Oconto	314 SE	R. 1, Box 89A, Oconto 54153
31.	Johnson, Raymond C. (R)	Eau Claire, Jackson, Monroe, Trempealeau	316 S	415 S. Farwell, Eau Claire 54701
32.	Knutson, Milo C. (R)	Crawford, Vernon, La Crosse	26A S	804 Cass St., La Crosse 54601
33.	Murphy, Roger P. (R)	1st, 2nd, 3rd assembly districts, Waukesha	32A S	1012 Hawthorne Circle, Waukesha 53186

1971 Wisconsin Senate

1971 Wisconsin Assembly



Members of the 1971 Wisconsin Assembly

District (Counties)	Name (Party)	Capitol Office Room	No.	Residence
Adams, Juneau and Marquette	Thompson, Tommy G. (R)	320	N	1201 Academy St., Elroy 53929
Ashland, Bayfield and Iron	Korpela, Ernest J. (D)	134B	S	633 E. 3rd St., Washburn 54891
Barron and Washburn	Schricker, Kenneth M. (R)	314	N	R. 2, Spooner 54801
Bayfield (See Ashland)				
Brown, 1st	Quinn, Jerome (R)	309	N	137 N. Oakland Ave., Green Bay 54303
Brown, 2nd	Kafka, Lawrence J. (R)	329	N	R. 3, Denmark 54208
Brown, 3rd	Vanderperren, Cletus (D)	5	S	R. 5, Green Bay 54301
Buffalo, Pepin and Pierce	Early, Michael P. (D)	335C	N	1052 S. Fork Dr., River Falls 54022
Burnett and Polk	Dueholm, Harvey L. (D)	14	S	Luck 54853
Calumet	Hephner, Gervase A. (D)	34	W	R. 4, Chilton 53014
Chippewa	Willkom, Terry A. (D)	26	W	R. 1, Box 20A, Chippewa Falls 54729
Clark	Oberle, Eugene W. (D)	26	W	R. 3, Stanley 54768
Columbia	Thompson, Robert M. (D)	329	W	R. 1, Poynette 53955
Crawford and Vernon	Lewison, Bernard (R)	329	N	11 S. Washington Heights, Viroqua 54665
Dane, 1st	Anderson, Norman C. (D)	216	W	5325 Marsh Rd., Madison 53716
Dane, 2nd	Nager, Edward (D)	327	W	Box 2036, Madison 53701
Dane, 3rd	Miller, Mrs. Marjorie M. (D)	6A	W	1937 Arlington Pl., Madison 53705
Dane, 4th	Everson, Harland E. (D)	336	N	R. 3, Box 750, Edgerton 53534
Dane, 5th	O'Malley, David D. (D)	5	S	315 W. Main St., Waunakee 53597
Dodge, 1st	Luckhardt, Mrs. Esther D. (R)	326	N	211 N. Hubbard St., Horicon 53032
Dodge, 2nd	Hanson, Thomas S. (D)	331	W	R. 1, Beaver Dam 53916
Door and Kewaunee	Swoboda, Lary J. (D)	32	W	507 Oak St., Luxemburg 54217
Douglas	Stack, Edward (D)	308	W	1420 John Ave., Superior 54880
Dunn	Baldus, Alvin (D)	8	S	1901 S. Broadway St., Menomonie 54751
Eau Claire, 1st	Looby, Joseph L. (D)	331	N	1156 E. Madison St., Eau Claire 54701
Eau Claire, 2nd	Mato, Louis V. (D)	5	S	Fairchild 54741
Florence and Marinette	LaFave, William G. (R)	307	N	R. 1, Box 215A, Peshtigo 54157
Fond du Lac, 1st	McEssy, Earl F. (R)	309	N	361 Forest Ave., Fond du Lac 54935
Fond du Lac, 2nd	Schwefel, William S. (R)	314A	N	R. 1, Oakfield 53065
Forest, Oneida and Vilas	Gaulke, Ellsworth K. (D)	11	W	Lac du Flambeau 54538
Grant	Azim, James N., Jr. (R)	335D	N	Muscoda 53573
Green and Lafayette	Tregoning, Joseph E. (R)	314B	N	R. 2, Shullsburg, 53586
Green Lake and Waushara	Wilcox, Jon P. (R)	304	N	Box 157, Wautoma 54982
Iowa and Richland	Duren, Joanne M. (D)	34	W	Box 234, Cazenovia 54924
Iron (See Ashland)				
Jackson and Trempealeau	Robertson, Alan S. (R)	330	N	118 East 4th St., Blair 54616
Jefferson	Wackett, Byron F. (R)	127	S	100 Oak Hill Ct., Watertown 53094
Juneau (See Adams)				
Kenosha, 1st	Molinaro, George (D)	119	S	424 44th St., Kenosha 53140
Kenosha, 2nd	Dorff, Eugene (D)	335A	N	8045 19th Ave., Kenosha 53405
Kewaunee (See Door)				
La Crosse, 1st	Greider, Gerald A. (R)	422	N	1729 Adams, La Crosse 54601
La Crosse, 2nd	Roberts, Virgil D. (D)	6A	W	427 Lee St., Holmen 54636

MEMBERS OF THE 1971 WISCONSIN ASSEMBLY (continued)

District (Counties)	Name (Party)	Capitol Office Room No.	Residence
Lafayette (See Green)			
Langlade and Oconto	McDougal, Milton (R)	307 N	402 Chestnut St., Oconto Falls 54154
Lincoln and Taylor	Sweda, Joseph (D)	240 N	Lublin 54447
Manitowoc, 1st	Helgeson, Donald K. (R)	318 N	937 N. 5th St. Manitowoc 54220
Manitowoc, 2nd	Bolle, Everett E. (D)	16 S	Forest Home Dr., Francis Creek 54214
Marathon, 1st	Day, Laurence J. (D)	11 W	R. 1, Eland 54427
Marathon, 2nd	Earl, Anthony S. (D)	134A S	917 Graves Ave., Wausau 54401
Marinette (See Florence)			
Marquette (See Adams)			
Menominee and Shawano	Grover, Herbert Joseph (D)	240 N	R. 2, Shawano 54166
Milwaukee, 1st	Menos, Gus G. (D)	13 W	5411 N. 19th St., Milwaukee 53209
Milwaukee, 2nd	Jones, Joseph E. (D)	16 S	4285 N. 26th St., Milwaukee 53209
Milwaukee, 3rd	Conta, Dennis (D)	134A S	3489 N. Hackett St., Milwaukee 53211
Milwaukee, 4th	Sanasarian, Harout (D)	17 E	1111 N. Astor St., Milwaukee 53202
Milwaukee, 5th	Sicula, Paul E. (D)	312 W	3287 N. 48th St., Milwaukee 53216
Milwaukee, 6th	Barbee, Lloyd A. (D)	131 S	321 E. Meinecke Ave., Milwaukee 53212
Milwaukee, 7th	Johnson, William A. (D)	10 S	3403 N. 22nd St., Milwaukee 53206
Milwaukee, 8th	Czerwinski, Joseph C. (D)	331 W	1230 S. 34th St., Milwaukee 53215
Milwaukee, 9th	Jackson, Robert L., Jr., (D)	310 W	7869 N. 57th St., Milwaukee 53223
Milwaukee, 10th	Kessler, Frederick P. (D)	13 E	2719 W. Juneau Ave., Milwaukee 53208
Milwaukee, 11th	Tobiasz, Raymond J. (D)	131A S	3145 S. 50th St., Milwaukee 53219
Milwaukee, 12th	Orlich, Sam L. (D)	312 W	1307 W. Mineral St., Milwaukee 53204
Milwaukee, 13th	Bultman, Glenn E. (D)	13 W	2556 N. Weil St., Milwaukee 53212
Milwaukee, 14th	Kleczka, Gerald D. (D)	9 W	3427 S. 9th Pl., Milwaukee 53215
Milwaukee, 15th	Wahner, James W. (D)	329 W	2732 N. 63rd St., Milwaukee 53210
Milwaukee, 16th	Pabst, Richard E. (D)	9 W	457 S. 74th St., Milwaukee 53214
Milwaukee, 17th	McCormick, John E. (D)	325 W	2954 S. Wentworth Ave., Milwaukee 53207
Milwaukee, 18th	Berger, David G. (D)	9 W	4443 N. 82nd St., Milwaukee 53218
Milwaukee, 19th	Hanna, Daniel D. (D)	13 W	2501 W. Henry St., Milwaukee 53221
Milwaukee, 20th	Klicka, George H. (R)	335E N	2115 N. 86th St., Wauwatosa 53226
Milwaukee, 21st	Lynn, James J. (D)	308 W	1126 S. 94th St., West Allis 53214
Milwaukee, 22nd	Vacant		
Milwaukee, 23rd	Rutkowski, James A. (D)	10 W	10223 Kay Parkway, Hales Corners 53130
Milwaukee, 24th	Atkinson, William P. (D)	336 N	1115 16th Ave., South Milwaukee 53172
Milwaukee, 25th	Sensenbrenner, F. James, Jr. (R)	335D N	Box 5471, Shorewood 53211
Monroe	Quackenbush, Robert L. (R)	324 N	510 Spring St., Sparta 54656
Oconto (See Langlade)			
Oneida (See Forest)			
Outagamie, 1st	Froehlich, Harold V. (R)	208 W	514 N. Drew St., Appleton 54911
Outagamie, 2nd	Rogers, William (D)	5 W	1800 Peters Rd., Kaukauna 54130
Outagamie, 3rd	Conradt, Ervin (R)	314A N	R. 2, Shiocton 54170
Ozaukee	Schowalter, Herbert J. (R)	318 N	642 S. Main St., Saukville 53080
Pepin (See Buffalo)			
Pierce (See Buffalo)			
Polk (See Burnett)			
Portage	Groshek, Leonard A. (D)	11 W	2125 Indiana Ave., Stevens Point 54481
Price, Rusk and Sawyer	Slaby, John W. (D)	335B N	Box 22, Phillips 54555
Racine, 1st	Ferrall, Michael (D)	335A N	1816 Wisconsin Ave., Racine 53403
Racine, 2nd	Brown, Manny S. (D)	304 W	2817 Ruby Ave., Racine 53403
Racine, 3rd	Stalbaum, Merrill (R)	127 S	R. 1, Waterford 53185
Richland (See Iowa)			
Rock, 1st	Mittness, Lewis T. (D)	302 W	730 N. Ringold St., Janesville 53545
Rock, 2nd	Mielke, Janet S. (D)	30 W	R. 1, Milton Junction 53564
Rock, 3rd	Johnson, Gary K. (D)	30 W	1818 Fayette St., Beloit 53511
Rusk (See Price)			
St. Croix	Mohn, Leo O. (D)	335C N	Woodville 54028
Sauk	Giese, Kenyon E. (R)	324 N	328 Dallas St., Sauk City 53583
Sawyer (See Price)			
Shawano (See Menominee)			
Sheboygan, 1st	Otte, Carl (D)	134B S	1440 S. 22nd St., Sheboygan 53081
Sheboygan, 2nd	Boeckmann, Vernon R. (D)	28 W	R. 2, Plymouth 53073
Taylor (See Lincoln)			
Trempealeau (See Jackson)			
Vernon (See Crawford)			
Vilas (See Forest)			
Walworth	Wilger, Clarence J. (R)	422 N	R. 4, Elkhorn 53121
Washburn (See Barron)			
Washington	Schroeder, Frederick C. (R)	335E N	R. 1, West Bend 53095
Waukesha, 1st	Merkel, Kenneth J. (R)	320 N	3405 N. Brookfield Rd., Brookfield 53005
Waukesha, 2nd	Alberts, John M. (R)	304 N	1228 W. Wisconsin Ave., Oconomowoc 53066
Waukesha, 3rd	Jackamonis, Edward G. (D)	331 W	622 Greenmeadow, Waukesha 53186
Waukesha, 4th	Shabaz, John C. (R)	205 W	21425 W. Glengarry Rd., New Berlin 53151
Waupaca	Byers, Francis R. (R)	314 N	357 Garfield Ave., Marion 54950
Waushara (See Green Lake)			
Winnebago, 1st	Guiles, Jon R. (R)	422 N	2010 Wisconsin St., Oshkosh 54901
Winnebago, 2nd	Bradley, Gordon R. (R)	314B N	2644 Elo Rd, Oshkosh 54901
Winnebago, 3rd	Ellis, Michael G. (R)	324 N	218 Clybourne St., Neenah 54956
Wood, 1st	Oestreicher, John C. (D)	335B N	911 S. Cherry Ave., Marshfield 54449
Wood, 2nd	Schneider, Marlin D. (D)	310 W	921 Washington St., Wisconsin Rapids 54494

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STATE MEDICAL SOCIETY PHOTOGRAPHY CONTEST

/INNING
HOTOGRAPHS
O RECEIVE AWARDS
ND WILL BE DISPLAYED
T THE ANNUAL MEETING

OPEN TO ALL MEMBERS OF THE STATE MEDICAL SOCIETY

Contest rules have been simplified to make it easier to enter your photographs.

All photographs entered should be mounted in the form in which entrant would like his prints to be exhibited. Mounted pieces should not exceed 16 inches by 20 inches. No frames will be accepted.

Prize winning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

A maximum of 10 prints may be entered by each entrant. All entries must be at the State Medical Society headquarters in Madison by April 24, 1972.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

Students, Physicians Evaluate Summer Externship

PHYSICIANS AND STUDENTS are enthusiastic about the new freshman medical student externship program with family physicians in Wisconsin.

This is the conclusion to be drawn from a recent evaluative report on the experiences of University of Wisconsin student participants and their supervising physicians. The report was compiled by Howard Stone, PhD, of the University of Wisconsin Center for Health Sciences from an opinionnaire completed by almost all UW students and supervising physicians who participated in the program during the past two years.

The externship program was established by the University of Wisconsin Family Medicine Club and initiated during the summer of 1969. It was quickly expanded the following year to include Medical College of Wisconsin students. Its principal purpose is to give the student experience in the primary sector of medicine at an early stage in his medical career.

The University of Wisconsin students spend ten weeks in a live-in situation with the physician and his family in smaller communities. Medical College of Wisconsin students spend ten weeks assigned to hospitals in the Milwaukee area.

All participating physicians are general or family practitioners and members of the Wisconsin Academy of Family Physicians (WAFP), which helped develop the program. WAFP has helped compile a list of physicians throughout the state who are interested in participating in the program. Students are matched to physicians primarily by geographic preference. During the summer, student and physician plan the student's experiences based on his own desires and interests.

Each participating student receives a $750 fellowship grant. The amount is necessary so that the student can keep his finances in some order, not work during the summer, and participate in an educational experience. The grants are administered through the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Funds for the past summer's program totaled over $37,500 for participating students from both medical schools. The money resulted from contributions by physicians, hospitals, Wisconsin Physicians Service (WPS Blue Shield), Surgical Care–Blue Shield, American Family Insurance, and the Wisconsin Rural Rehabilitation Corporation.

In addition to providing a broad understanding of health care and the role of the physician in the community, it is hoped this project will encourage students attending Wisconsin medical schools to establish their practices in this state.

During the past summer 36 University of Wisconsin medical students externed with physicians in Adams–Friendship, Amery, Antigo, Baldwin, Baraboo, Barron, Big Bend, Chetek, Cumberland, Darlington, Dodgeville, Eau Claire, Fond du Lac, Galesville, Hales Corners, Hartland, Hayward, Madison, Manitowoc, Menasha, New Richmond, Oconto, Oconto Falls, Pardeeville, Prairie du Sac, Rice Lake, River Falls, St. Croix Falls, Shawano, Shell Lake, South Milwaukee, Spooner, Stoughton, Sun Prairie, and Superior.

Medical College of Wisconsin students, 11 in all, were assigned to hospitals in Cudahy, Milwaukee, Menomonee Falls, Mt. Calvary, and Waukesha.

The evaluative report of Professor Stone follows on the next page.

Two New Versions of Lilly Drug Abuse Exhibit Available

In keeping with its ongoing search for new ways to support efforts of pharmacists, physicians, and educators in combating drug abuse. Eli Lilly and Company is pleased to announce the availability of two new versions of the Lilly Drug Abuse Exhibit.

This exhibit may be obtained on loan from Lilly by state, county, and local pharmaceutical and medical associations and by schools of pharmacy and medicine, for sponsorship by the association or school at state or county fairs, health fairs, or other appropriate gatherings of the public. Space is provided above the film screen for identification of the sponsoring organization.

The three versions of the Lilly Drug Abuse Exhibit that are now available differ according to the slidetape presentation featured: (1) *Trends In Drug Abuse*, (2) *What Would You Tell A Friend?*, and (3) *Students Look At Drugs*.

SUMMER EXTERNSHIP

An Experience in Primary Care—Evaluative Report

By HOWARD L. STONE, PhD, Madison, Wisconsin

During the summer of 1971, a total of 36 University of Wisconsin freshman medical students spent ten weeks as an extern with a family practitioner in various size communities throughout the State of Wisconsin. This program, developed under the sponsorship of the Family Medicine Club at the University of Wisconsin in cooperation with the Wisconsin Academy of Family Physicians, is in its third year of existence. This past summer both students and physicians who participated in the program during the past two years were requested to provide evaluative information on their experiences. A total number of 50 out of a possible 53 students and 32 out of a possible total of 36 physicians responded to an evaluation opinionnaire. Figure 1 shows the data that were obtained.

Figure 1

As noted in Figure 1, the majority of the externships during the summer of 1970 and 1971 were located in cities with a population of 10,000 or less. In keeping with the overall purposes of the program, the experiences accomplished the purpose of exposing students to primary care in smaller sized Wisconsin communities.

The externship is also designed to provide the medical student with the opportunity to reevaluate his interest in becoming a practicing physician. The Medical School curriculum does not formally expose students to patients until the third year followed by an 8-week preceptorship experience in the fourth year. The externship program gives students an opportunity to see first hand what a practicing physician in primary care does and to self-assess their interest in this area. In response to the following questions:

My summer externship experience had the following effect on my interest to become a physician:

The student responses were as follows:
Reinforced my desire: 47
Did not affect my interest level: 3

Student Reactions to the Program

Students were asked to respond on a nine-point rating scale the degree to which they expected certain types of involvement during the externship as compared with the actual involvement they did ex-

Student Reactions to Expected and Experienced Involvement—Mean Score Comparisons

Rating Scale: Greatly Involved 1 2 3 — Involved 4 5 6 — Not Involved 7 8 9

Number of Responses — N = 50

Degree of Involvement	Degree of Expectation	Actual Involvement	Significance of Difference
1. Patient Contacts	2.48	2.88	N.S.
2. Learning Mechanical Skills	4.40	3.88	N.S.
3. Interaction with Paramedical Personnel	3.70	3.02	P > .05
4. Therapeutics	5.32	4.82	N.S.
5. Viewing Social–Community Interaction of Physician	3.66	3.46	N.S.
6. Student–Physician Contact	1.92	1.96	N.S.

Figure 2

A Rank-Order Correlation of the Expected and Experienced Involvement Indicated

Agreement Between Student Expected and Experienced Involvement Rank-Order Correlation

Area of Involvement	Expected Rank	Experienced Rank
—Student–Physician Contact	1	1
—Patient Contacts	2	2
—Viewing Society–Community Interaction of a Physician	3	4
—Interaction with Paramedical Personnel	4	3
—Learning Mechanical Skills	5	5
—Therapeutics	6	6
Correlation = .94	P > .01	

Figure 3

Copies of a complete summary of the student and physicians' evaluations of the externship program are available upon request from: Howard L. Stone, PhD, University of Wisconsin Center for Health Sciences, 1402 University Ave., Madison, WI 53706.

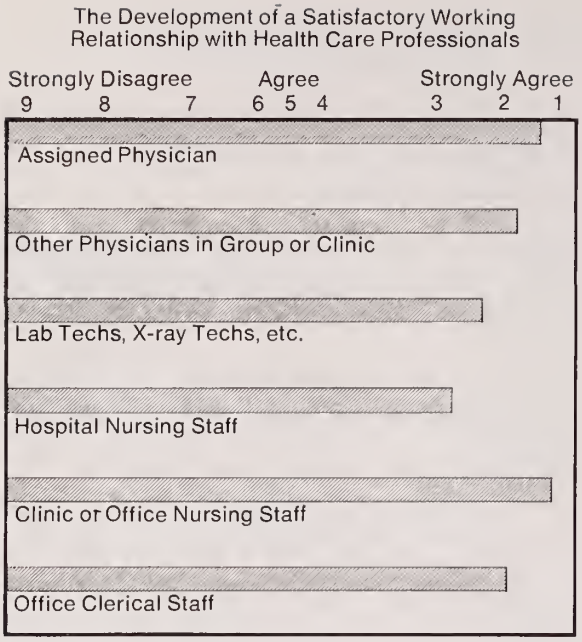

Figure 4

perience. Figure 2 indicates the student responses in regard to involvement.

The data reported in Figure 2 is significant since it indicates the externship experiences did in fact provide students with the opportunity for involvement in the areas they had expected to be involved. The program is accomplishing its stated objectives.

Another area of concern in the development of the externship program has to do with the opportunities provided for the medical student to develop a working relationship with health care professionals in the local community. In response to a nine-point rating scale students indicated the degree to which they agreed they were provided an opportunity to develop a satisfactory relationship with designated individuals (Fig 4).

The data in Figure 4 indicate that students agreed that they were provided the opportunity to develop a satisfactory working relationship with the designated individuals.

Did the externship experience influence the students perspective of primary medical care?

Students response to this question indicated the following:

I did develop a different perspective of primary medical care: 34

I did not: 16

$$X^2 = 6.28 \; P > .05$$

Those 34 students who did indicate the externship changed their perspective indicated the following specific changes:

1. Primary medical care can best be provided through a group practice—it is very difficult in solo practice.
2. The primary care practitioner is primarily a diagnostician.

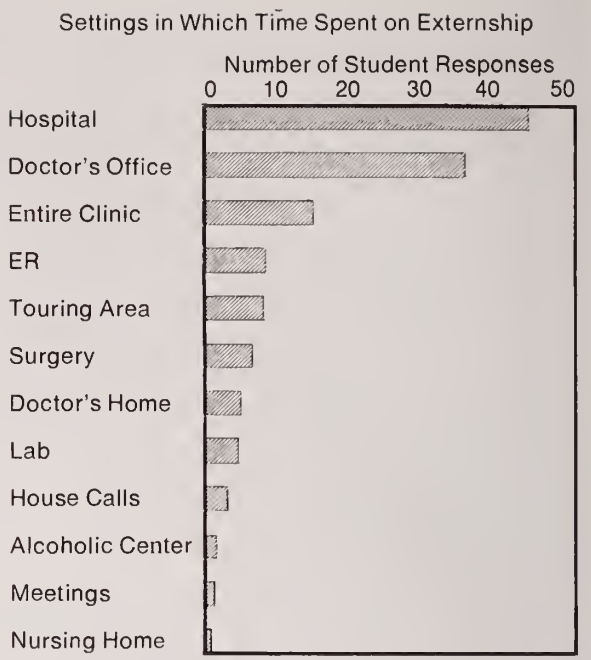

Figure 5

3. Competent general practitioners must be extremely knowledgeable.
4. This is a more personal way to practice medicine.
5. Realized the tremendous importance of relating to patients.
6. The primary care physician is the most valuable doctor in the eyes of the patient in a small community.
7. There is a tremendous amount of paperwork involved in the administration of primary care.
8. Realized the dependence of the patient on his health care team.

Where can students expect to spend the major portion of their time on the externship?

Students were asked to indicate the types of settings in which most of their time was spent. Figure 5 indicates the number of students responding to three types of settings in which they felt most of their time was spent.

Orientation Activities

Students were asked to indicate the type of information or orientation activities that would have been helpful in making the externship a more valuable learning experience for them. They indicated the following:

1. The present set-up is good. Flexibility of the program, leaving the actual scheduling up to the student and the physician is advantageous.
2. More knowledge of the fundamentals of physician diagnosis.
3. Provide the participating physicians with a synopsis of the learning experiences the student had in the first year of Medical School.

What types of activities did the students perceive as being most helpful?

In response to this inquiry the following responses were indicated:

1. Observing surgery
2. Emphasis on the importance of anatomy
3. Emergency room experience
4. Work with x-ray and lab technologists
5. Interviewing patients
6. Observing how the doctor deals with patients
7. OB experience
8. Observing the health care team work as a unit
9. Observing inter-physician relationships
10. Getting involved in taking histories and doing physicals

What types of activities did the students perceive as being least helpful?

In response to the inquiry the following responses were indicated:

1. Waiting around for something to "happen." The physician should have activities scheduled to provide for active participation of the student.
2. Getting overly involved in office routine.

Overall Evaluation of the Externship as a Learning Experience for Students

Excellent:	42
Good:	7
Average:	1

Students overwhelmingly rated their externship as an excellent learning experience.

Reactions of the Participating Physicians to the Externship

Thirty-two out of a total of 36 physicians participating in the externship program took time to complete and return a reaction opinionnaire at the end of summer 1971. This type of response is evidence that the physicians have a high degree of interest in the program. In addition, 30 out of the 32 respondents indicated they plan to continue as a participant in the 1972 externship program. The other two were undecided.

In response to various questions, the physicians indicated they strongly agreed that:

1. The student's *academic preparation, mechanical skills,* and *capacity* to *accept responsibility* compared favorably with their expectations.
2. The obligation of having a student present did not create difficult problems to handle.
3. They developed a better understanding of the problems facing medical students.

What were some of the specific advantages of the externship for the participating physician?

The following were indicated most frequently:

1. The opportunity to participate in medical education, i.e., practice a latent desire to teach.
2. The opportunity to provide a meaningful exposure to family practice.
3. The opportunity to meet students. Restored faith in today's students.
4. Sharpened attention given to academic medicine.
5. Fresh ideas and stimulating questions caused the physician to reevaluate customary procedures.

Many of the physicians indicated that a brief resumé of courses the student had taken would have been helpful to them in assuming their role as "teacher." The physicians also were asked to indicate whether the externship provided the opportunity for the student to contribute as a worker. Their response to this question best describes the physicians' positive attitudes toward the externship. They indicated *no* to this question, but more significantly indicated they did not view the student as a laborer, but rather as a person there to observe and learn. They saw themselves not as an employee, but as a teacher.

PLACEMENT SERVICE AIDS DOCTORS AND COMMUNITIES

Do you want an associate? Generalist or specialist? Call 257-6781, area code 608; or write Box 1109, Madison, Wisconsin 53701.

The Placement Service of the State Medical Society of Wisconsin has helped many physicians find a new associate, found promising locations for young practitioners, and brought resident medical service to many communities without a doctor.

Here is how the Placement Service may be able to help you. The Society maintains a continuous listing of names and biographical data on physicians who wish to locate in Wisconsin. Usually there are 125 to 150 physicians listed in all categories. The Society also maintains a list of physicians and communities offering opportunities in individual, group, and other types of practice. THE WISCONSIN MEDICAL JOURNAL offers a Physicians Exchange service in the Medical Yellow Pages each month at reasonable rates. Widows of deceased physicians who were members of the Society may use this service without charge.

Physicians who have used the Placement Service have described it as quite effective. JOURNAL advertising, too, has proved highly successful.

One word of advice: Tell the Society of your needs as soon as possible. More time usually means better results.

THE CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION was founded in 1954 to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Medical Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The Scientific Medicine activities of the Foundation include in-depth teaching programs, speakers service for county medical societies, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The voluntary contributions recommended by the House of Delegates are being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the Foundation are deductible for income tax purposes.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1972–June 20, 1972

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN—BUREAU FOR CRIPPLED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*
Manitowoc	February 16 and 17
Kenosha	March 1 and 2
Stevens Point	March 15
Superior	April 4
Ashland	April 6 and 7
Racine	April 12 and 13
Chippewa Falls	April 18
Eau Claire	April 19
Rhinelander	April 26 and 27
Sheboygan	May 3 and 4
Lancaster	June 7
Darlington	June 8

FOR: Clinics conducted by the Bureau for Crippled Children of the Division for Handicapped Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Division for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Division for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

PRESIDENT'S PAGE

Wisconsin Health Care Review Incorporated

WISCONSIN HEALTH CARE REVIEW INCORPORATED was incorporated on December 29, 1971, as a joint venture of the Wisconsin State Dental Society, the Wisconsin Hospital Association, and the State Medical Society of Wisconsin. As far as we know it is the first peer review organization to include more than one profession. This corporation will enable those who pay health care bills with a readily available place to turn when questions about quality of care or use of services arise, especially when more than one health profession is involved.

It should be emphasized that WHCRI is not meant to replace any existing peer review. It is merely a mechanism to advise, coordinate, and supplement existing groups such as regional or county peer review committees and hospital utilization committees. It will make its reviewing and consulting services available to health care providers and professional organizations representing such providers and to those who pay health care bills such as the insurance industry and the government. In general the existing peer review mechanisms will be utilized to accomplish this.

For those who disagree with the principle of peer review, let me remind you that for years you have practiced with peer review. Hospital tissue committees have functioned for years. Hospital utilization committees have been with us since Medicare began. Local county insurance committees have functioned with success.

Peer review can best be thought of as a self evaluation because it causes each of us to evaluate our fees, our utilization habits, and our own quality of care. This is accomplished because we know other doctors are also evaluating us. It is far better that our peers do this because they have the knowledge and understanding to fairly advise us. A governmental agency would have neither the knowledge nor the understanding to fairly judge our professional quality and/or fees.

G. A. Behnke M.D.

G. A. BEHNKE, MD

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

1. And we hardly noticed the change . . .

THOSE OF US WHO ARE OLD TIMERS will recall with a startle the almost chauvinistic tone to the letter quoted below regarding formation of a state medical auxiliary. The Woman's Auxiliary has now become such a vital part of medical activity, in so many ways, that these comments written to Mr. J. G. Crownhart, in 1929, seem scarcely possible. To the younger members of our group it will have historical interest and will vindicate the efforts of both men and women through the years to change significantly the role of women. I only hope that my counterpart forty years from now will not be as gleeful over some of my writings as I was to find this letter to Mr. Crownhart, written by his counterpart in the medical society of a nearby state.

The letter, dated November 30, 1929, reads in part:

"Dear George: My personal reaction on the auxiliary is favorable. In some county societies the auxiliary is a real addition to medical organization and *when its activities are confined to entertainment** little criticism has arisen against it.

"In . . . (name) . . . county where so many nationalities are represented among those practicing medicine, the problem of an auxiliary has been a very delicate one.

"The entertainment of physicians' wives and families at the annual meeting usually is left up to the local auxiliary of the city in which the meeting is held. The state auxiliary usually has a breakfast or luncheon meeting at which a short business session is held and a talk is made by some outstanding medical *man*. This year at . . . (city) . . . Dr. . . . (name) . . . made this talk, his subject being 'Mrs. Gullible's Travels in Cosmetic Land.'

"Some physicians are very much opposed to the auxiliary and at least in one district of the state there is criticism that certain women are using the auxiliary to get in the limelight.

"Personally, I think the auxiliary adds rather than detracts from the *general gaity and joy* of the world in general, and if *properly curbed*, of medical societies in particular. Yours sincerely."

* All italics by editor, including the word "curbed."—RH

2. But this change we will notice . . .

It is becoming increasingly apparent that scientism, as we understand the concept in the practice of medicine, may be rapidly slipping into history. Along with attitudes toward women as a sort of curious frill on the edge of the real work of the world, as discussed above, we need turn our attention to another change. The role of the physician as dispenser of medical knowledge is shifting too. No longer is the doctor seen as the ultimate source of wisdom. In the early years of this century we, as a group, were accorded truly charismatic capacities. In the intervening decades the general wisdom, as seen by our public, has lessened considerably. In the past decade, even our earned and justified role as medical arbiter has faded, we hope not into history. We cannot with justice deny the consumer (patient) his right to a voice in what happens to him in the process of health delivery, either content or cost. But I hear increasingly strident voices raised against this consumer voice, when the consumer chooses something other than our well tested viewpoint. We, as doctors, have never been in this position before. When the majority of the members of both the Senate and the Assembly vote to include the chiropractic in what government will pay for *if chosen by the patient,* we gasp in astonishment. Our voices rise against the governor who signed the bill, against each other for not doing more, against the legislators who responded to "political" pressure, and loudly lament the fate of the patient who chooses a back manipulation to an orthopedic consultation for his pain. It may well be that all of these attacks are correctly aimed. Or they could be but impotent rage to stop a social movement, characterized by movement toward total involvement. This seems to be upon us, in fields far from medicine, as well as in our specialties. The third party, and the fourth party, and others will be having their say—and this change will not be easy to take. In theory, better service will result. In actuality, giving full choice to the consumer may well provoke crass forms of competition. To give the patient what he thinks he wants—for example temporary reassurance, symptom relief, laying on of hands—may break the back of our hard earned scientific method. Has free choice of physician become confused with free choice of methods of healing?—RH

3. And this change might occur . . .

To let fantasy run full can be entertaining, can be frightening, but it also can point up a trend. This formula, published in the Milwaukee Medical Times in July of 1969 came from some unknown focus in my thalamus, or perhaps from my id, following several curious changes in the medical student's role in his own education. It is an exaggeration of course, but listen, as the winds of change are upon us in this issue.

Medical Education—1984

A formula has been prepared, which may simultaneously solve the financial problems of medical education, and the burgeoning demands of students. The plan is relatively simple. It involves convening all applicants for medical school once a year. At this meeting, a series of tests will be administered, and each applicant scored on the following formula:

$$MQ = k \sqrt{\frac{a + s + l}{(i) + (e)}} + F\ (MCAT)$$

In this formula, MQ, of course, stands for Medical Quotient—

k = charismatic flair
a = aggressivity
s = appearance of sincerity
l = physical looks
i = capacity for self-discipline
e = intellectual curiosity
F = Firearms skill

And, MCAT stands for Medical Comprehensive Aptitude Test.

All applicants will be scored on this scale. Only the top 100 will be retained. Of this group, the top 10% will be granted their MD immediately upon payment of tuition fees, and based on their own assertion.

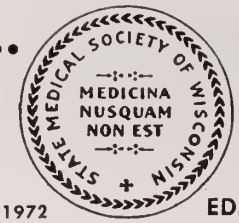
The other 90% will be required to spend one year reading, thinking, and traveling in whatever way that they judge best to perfect their skills as a physician.

All members of the faculty of the School of Medicine below the rank of full professor will be dropped, thus saving some money. Full professors will be available at all times to the body of students who are undertaking their medical education at their own initiative. Professors will be expected to listen to students and to learn from them. Those students who are not otherwise occupied will be granted their MD automatically, on paying their tuition, in the Spring.

The entire process will be repeated the next year, using whatever number of students are necessary to supply the medical needs of the country as determined by a selected panel of political figures.—RH □

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

SECTION 

OPHTHALMOLOGY

JANUARY 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

JOINT MEETING OF TWO COMMITTEES

A joint meeting of the executive and legislative committees of the Section was held at the State Medical Society building in Madison on Oct. 27, 1971. Those present were: MDs Elmer E. Johnson, Madison, chairman; George H. Anderson, Stevens Point, chairman-elect; W. Carson Parks, Milwaukee, secretary; Herbert Giller, Milwaukee; James V. Bolger, Jr., Waukesha; Edward J. Zeiss, Appleton; Michael J. Belson, Appleton; Dwain E. Mings, Monroe; James C. Allen and Robert B. Andrew, Madison. Also present were H. B. Maroney and W. Pharis Horton, staff member and consultant respectively of the State Medical Society of Wisconsin.

Doctor Johnson reported on the Learning Disabilities Conference which he attended last summer in Atlantic City as a representative of the Section on Ophthalmology. Discussion then turned to what was being done in the state of Wisconsin about the dyslexia problem. It was noted that teachers look to the medical profession to cure students with learning disabilities; and when the profession cannot give them a simple solution, they listen to anyone who promises them results. Some of the ophthalmologists reported that they had heard of a few optometrists convincing teachers and parents to allow students to undertake lengthy and costly courses of treatment. It was agreed that a symposium should be held on learning disabilities to which educators, legislators, and interested persons could be invited for educational purposes. It was agreed that the Section should explore the possibility of presenting a program on learning disabilities at the State Teachers Convention in 1972.

A status report was given on the funding proposal for an optometric school at the University of Wisconsin–La Crosse. It was noted that the cost per student for the training of optometrists at some other schools that had been started had been much higher than for training medical students. It was decided that the Wisconsin Regional Medical Program should be offered the consultative services of an opthalmologist when the optometric study is brought back to that organization for further review. There is no ophthalmologist on the board of directors of the Wisconsin Regional Medical Program.

Members considered legislation which would give funeral directors the right to remove eyes for Eye Bank purposes when the deceased patient had given proper consent. It was agreed that further information should be obtained from the Eye Bank on what actually is wanted and this information should be distributed to Section members before a position is recommended to the Commission on Public Policy of the State Medical Society.

The current status of the bill to provide for certification of dispensing opticians was reviewed and it was determined that Mr. Whittow of the Wisconsin Society of Opticians should be contacted to determine how the Section can best help in the passage of this legislation.

Doctor Bolger agreed to develop in detail a proposal to use ophthalmologists and ophthalmology residents to staff a mobile unit on eye care for Menominee County and other depressed areas of the state.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

The Milwaukee Ophthalmological Society is sponsoring a program on "Learning Disorders" with multi-panel representatives of education, ophthalmology, pediatrics, psychiatry, and neurology. All interested persons and their guests are welcome. The program is scheduled for January 25 at 8 p.m. at the University Club in Milwaukee.

WISCONSIN LIONS EYE BANK REPORT

The Wisconsin Lions Eye Bank committee met December 9. Besides the Lions Club representatives physicians attending were Robert A. Hyndiuk, Arthur C. Kissling, and Richard O. Schultz, Milwaukee; Guillermo de Venecia and James C. Allen, Madison.

During the months of July, August, and September 1971, Madison received 76 eyes that were used as follows: corneal transplants 29, scleral preservation 5, practice surgery 4, and research 35. During the same period, Milwaukee received 39 eyes that were used as follows: corneal transplant 5, corneal preservation 3, research 20, and residents' training 11.

DATES TO REMEMBER

Jan. 25: Milwaukee Ophthalmological Society. Dyslexia Symposium.

Feb. 22: Milwaukee Ophthalmological Society. Morton F. Goldberg, MD, Chicago—Clinical Genetics and Genetic Counseling. □

NEWS HIGHLIGHTS

"Year of Pathology" Starts in Wisconsin

The Wisconsin Society of Pathologists has joined its national organization in promoting a "Year of Pathology." The theme will reflect the pathologist organizations' efforts in education and research.

In Wisconsin the movement began in November 1971 when the Pathology Department of the Medical College of Wisconsin, Milwaukee, moved into its new educational and research building where all research activities will be centered.

The building, which also will be used for teaching purposes starting in late January, will be formally dedicated on May 4 and 5. It was built on Milwaukee County land with funds from the Medical College and the Pathology Department.

Although plans for the dedication program have not been finalized, it is anticipated that a number of well known workers in various parts of the country will be invited to speak on both anatomic and clinical pathology.

Chesley P. Erwin, MD* of Elm Grove is president of the Wisconsin Society of Pathologists and J. M. B. Bloodworth, Jr., MD* of Madison is chairman of the scientific program committee.

Madison Area Physicians Appointed to UW Medical School Clinical Faculty

Eleven Madison area physicians have been appointed to the clinical faculty in the family practice program at the University of Wisconsin Medical School by Acting Dean Henry C. Pitot, MD.* Six were named assistant clinical professors and five were appointed clinical instructors.

Appointed assistant clinical professors were: MDs Gerald J. Derus,* Monona; Edward H. Kolner,* James N. Moore,* B. E. Stein,* and Walter L. Washburn,* Madison; and William T. Russell,* Sun Prairie.

Named clinical instructors were: MDs John G. Albright,* James T. Gascoigne,* Haldor P. G. Barnes,* and Martin C. Havel,* Madison; and R. F. Korbitz,* Monona.

The physicians have participated over the past three years in development of the family practice program and continue to teach medical students and residents in the training program.

Those appointed assistant clinical professors are board certified by the American Board of Family Practice. They bring to eight the board certified faculty members, believed to be the largest number in any family practice teaching program in the nation.

The program is directed by John H. Renner, MD* and the assistant director is Richard Shropshire, MD.*

Dr. Charles Landis Named Full-time Med. Director, St. Mary's Hill Hospital

The Board of Directors of St. Mary's Hill Hospital in Milwaukee has appointed Charles W. Landis, MD* as the full-time medical director.

Prior to this appointment, Dr. Landis was associated with the hospital on a part-time basis. He served as director of mental health of Milwaukee County from 1958 to 1971.

Dr. Landis

Dr. Landis, a resident of Elm Grove, holds teaching positions at the Medical College of Wisconsin where he is chairman, Section on Community Psychiatry, and associate professor of psychiatry. From 1966 to 1969 he was a professor of clinical psychiatry and social welfare at the University of Wisconsin–Milwaukee.

St. Mary's Hill is a private, nonprofit psychiatric hospital.

PHYSICIAN BRIEFS

Eugene J. Birkmeyer, MD

. . . Rhinelander, recently joined the medical staff at St. Mary's Hospital, Rhinelander. He is a graduate of the University of Minnesota Medical School and served his internship at Minneapolis General Hospital. He also served in the United States Air Force.

Thomas K. Resan, MD

. . . Minocqua, recently became associated with the Lakeland Medical Associates, Inc., in Minocqua. He graduated from the University of Wisconsin Medical School and completed his internship at Gundersen Clinic and Lutheran Hospital, La Crosse.

George D. Williamson, MD

. . . Marshfield, recently joined the medical staff of the Marshfield Clinic. An orthopedic surgeon, Doctor Williamson interned at Buffalo General Hospital, New York, and did his residency in general surgery at Detroit General Hospital. Four years of residency in orthopedic surgery followed at the University of Kentucky Medical Center, Lexington, and prior to joining the Clinic, he specialized in children's orthopedic surgery at the University of Manitoba Hospital, Winnipeg, Canada.

Milton Miller, MD*

. . . Madison, chairman of the Department of Psychiatry and the Psychiatric Institute at the University of Wisconsin, recently resigned his position to take a similar post at a Canadian university. He has been on the UW faculty for 17 years and department chairman and institute director for 10 years.

Donald J. Welter, MD*

. . . Shell Lake, recently was named a charter diplomate of the American Board of Family Practice.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

MDs, Nurses, Patients Have Library On Call

Electronics in medicine has taken on another dimension recently. Two familiar pieces of equipment, the telephone and the tape recorder, have been put to use in a quick access library with separate sections for physicians, nurses, and patients.

The library is made up of tape recordings of from four to seven minutes long. Any time of the day or night the physician, nurse, or patient can use the library by dialing the tape switchboard, located in the General Services and Communications Division of the University of Wisconsin, Madison. The caller merely requests the tape he wants to hear and then sits back and listens while it is played. Each library telephone is connected to a tape repeater. A self-winding cartridge is placed on the machine by the person who answers the call, and service cuts off automatically when the tape ends.

Started in 1966

The library's oldest section started in 1966 with 88 tapes for physicians. At present there are over 500 MD tapes on a variety of medical subjects, ranging from abdominal aortic aneurysm to water intoxication. The University of Wisconsin initiated it to help physician continuing education and to provide immediate access to up-to-date reference material.

Originally, the physician was required to pay any toll telephone charges necessary to reach the library. Early reaction to the idea was so encouraging that in 1967 a WATS (Wide Area Telephone Service) telephone line was installed, providing toll-free access to the library for physicians within the state. This was made possible by Wisconsin Regional Medical Program (WRMP) sponsorship of the project.

Nursing Tapes Follow

The following year, WRMP funded establishment of the second section of the library—tapes for nurses. This section includes tapes from the MD library likely to be useful to nurses along with 60 nursing tapes on new procedures and equipment and other recent developments in nursing.

Nursing Dial Access is primarily intended to meet the needs of the nurse practicing in an isolated setting: public and occupational health, rural hospitals, nursing homes, and schools. Others using it are nursing students and inactive nurses who continue to have interest in their profession.

Patient Information Service

In 1971, the third section of the library went into use—patient information. It was set up to answer the questions of patients at the University of Wisconsin Medical Center. Physicians, nurses, and other health personnel often do not have the time to talk to each patient about tests, treatments, and hospital procedures. The 50 tapes for patients include information about the hospital, medical procedures, medication, special diets, and home care. In addition to being factual, all of these tapes are designed to be helpful, understandable to the public, and generally reassuring.

All three sections of the library have been well received. Physician and nurse libraries are located in both Madison and Milwaukee. In Milwaukee the library is maintained at Milwaukee County General Hospital for physicians and other hospital personnel there as well as Medical College of Wisconsin students.

Expanded to Other States

Special telephone lines have given Minnesota and North Dakota MDs access to the MD library along with all the physicians associated with AT&T. In 1971, all Veterans Administration hospitals on the Federal Telephone System came into the program.

In addition, the tapes have been available to all other Regional Medical Programs (RMPs) and to Medical Schools at a low cost. The complete MD library has been sold to RMPs in Arizona, Arkansas, Alabama, Northwestern Ohio, Oklahoma, and West Virginia. Parts of the library have been purchased by New Mexico, Central New York, North Carolina, Intermountain (Utah), New Jersey, and Missouri. Medical schools with the tapes are located at the University of Saskatchewan (Saskatoon, Canada), University of Nebraska, and Indiana.

There have been over 33,000 physician and medical student calls since the Wisconsin physician dial access library opened. Those most frequently using the program have been general practitioners in smaller communities.

The most common problem about which information has been sought has been the Rh problem of the pregnant patient. Others most frequently requested are one on "Marriage on the Rocks" and many in areas of cardiovascular disease. There is also general high interest in tapes related to allergy, psychiatric problems of the family MD and problems related to diabetes, strokes, renal failure and cancer.

On Subscription Basis

On September 1, 1971, the Dial Access program went on a subscription basis for Wisconsin MDs using the library. A $25 yearly charge entitles the subscriber to unlimited use of the tapes. A new brochure for subscribers lists all the 500 tapes in the MD library and a new number to call for the service.

Since the start of Nursing Dial Access some 40,000 calls have been received. The nursing tapes have been made available at no cost to other Regional Medical Programs and university medical and nursing schools. Several neighboring states are exploring a tie-in with Nursing Dial Access and a number of states are using the nursing tapes in their own programs.

Helps Communication

A recent evaluation of the first 18 weeks of the patient information service showed that both patients and hospital personnel found it an excellent means of communicating needed information. There were 674 calls received in the first six months of operation. It is expected that there will be greater use of the service as University Hospitals have more patient telephones and as the number of selections in the tape library grows.

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- Full benefits are payable regardless of any other insurance you may have.

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CHATTANOOGA

TV Course on Drugs Starts in February

"Psychology of Drug Use . . . and Abuse" is the title of a 30-program educational television series starting next month on TV stations throughout the state.

The University of Wisconsin–Oshkosh is providing the interdisciplinary series, which is available for three graduate or undergraduate credits or an attendance certificate. Lecturers will be from the fields of law, psychology, psychiatry, sociology, pharmacology, insurance, and journalism.

The series is to be a comprehensive, indepth study of the drug problem as it affects our society today. It is intended for educators, businessmen, and professional people who have a definite concern for controlling drug abuse. Emphasis is placed on the social pressures that contribute to the problem. The course covers the personality characteristics of drug abusers, identity and characteristics of drugs most commonly abused, legislation, and various treatment programs now available.

The series will be carried by eight television stations, both educational and commercial, making it available to every television household in Wisconsin and to limited audiences in Illinois, Iowa, Minnesota, and Upper Michigan.

To limit tape duplication costs, the course will begin on different days in different locations. The series will start at 6:45 a.m. February 14 on Channel 8 in Duluth/Superior, Channel 2 in Minneapolis/St. Paul, and Channel 11 in Green Bay. Four other stations (Channel 40 in Dubuque, Channel 19 in La Crosse/Eau Claire, Channel 27 in Madison, and Channel 19 in Wausau/Rhinelander) will show the first program February 21 at 6:45 a.m. On all seven of these stations the series will be shown Monday, Wednesday, and Friday mornings from 6:45 to 7:30. Milwaukee's Channel 36 will begin the series on February 28 with programs scheduled for Monday, Wednesday and Thursday evenings from 8:00–8:45.

The series is ten weeks long and fees are charged according to the type of credit desired. Course requirements include three written independent study projects and two examinations.

Complete registration and program information is available from the University of Wisconsin–Oshkosh Division of Extended Services.

Dr. R. L. Johnson President of Wood County Society

Robert L. Johnson, MD* of Wisconsin Rapids was elected president of the Wood County Medical Society at its December meeting in Marshfield.

He succeeds Thomas J. Rice, MD* of Marshfield. Raymond L. Hansen, MD,* Marshfield, was elected vice-president and Francis Kruse, Jr., MD,* Marshfield, was reelected secretary–treasurer.

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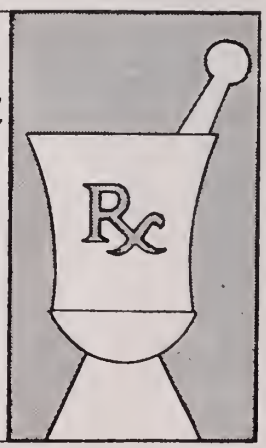

Report Describes State's Physicians

Physicians in Wisconsin have been tabulated, categorized, grouped, and studied and the resulting statistics compiled in a recent State Division of Health report "Description and Distribution of Wisconsin Physicians 1970."

Based on data supplied by the American Medical Association and the American Osteopathic Association, the report is composed of a series of tables correlating such factors as Wisconsin physicians' type of practice, age, employer, place and time of medical school graduation, specialty, and location.

The report shows that as of the end of 1970 there were 5,340 physicians actively engaged in medical practice in the state of Wisconsin. This includes 5,215 medical doctors and 125 doctors of osteopathy. Of these, the vast majority, 4,195 (79%), are working directly in the care of patients rather than in other activities such as administration, medical research or teaching. In addition there are 313 physicians in Wisconsin who are not actively practicing medicine, because they are retired or disabled or for some other reason.

Solo Practice Dominant

Among some of the more interesting findings that can be drawn from the report are figures showing that more physicians in all types of patient care are in solo practice than are in partnerships, group practice, or other arrangements.

Other tables in the report break down the state's physician population into regions and provide comparisons on MD ages and type of practice by region as well as showing where the graduates of Wisconsin's two medical schools are practicing.

The figures show that about 31% of the physicians in the state's northwestern area are between 50 and 59 years old, while the other seven districts have from 17% to 22% of their active, direct care physicians in this age range. In the northwest district 31% of the physicians are between 35 and 49, while the other seven districts have between 42% and 50% of their direct care physicians in this range.

Other tables indicate that graduates of Wisconsin medical schools now taking care of patients in Wisconsin are clustered along Lake Michigan in greater concentrations than elsewhere. About half of the active, direct care physicians in these areas are Wisconsin medical school graduates. In contrast, on the opposite side of the state (the southwest and northwest corners) slightly over a third of the practicing physicians are Wisconsin medical school graduates.

These figures on Wisconsin medical school graduates include physicians in residency training. However, residents as a group are composed of only one-third Wisconsin medical school graduates.

Majority Not Wisconsin Grads

The report also counts those doing internships in Wisconsin among the state's active physicians in the direct care of patients. Of Wisconsin's 152 interns in 1970, only 20% were graduates of Wisconsin medical schools.

The vast majority of all interns and residents are employed in a hospital-based training program. All work under the supervision of fully licensed physicians.

Wisconsin's medical researchers and teaching physicians have also been drawn in large part from medical school graduates of other states and countries. Only 27% of these researchers and teachers graduated from Wisconsin medical schools. The Division of Health report shows that in 1970 the state had 241 medical research and teaching physicians.

The report was prepared by the Division of Health's Bureau of Health Statistics at the request of the Bureau of Comprehensive Health Planning.

Dr. Dietsche Hosts NC Wis. Orthopedic Society

Wolfgang O. W. Dietsche, MD* of Wisconsin Rapids was host November 13 to the North Central Wisconsin Orthopedic Society. Several interesting cases were presented including Girdlestone type operations in which the results seemed to be good.

The spring meeting will be held in Wausau, according to the president, Thomas O. Miller, MD* of Wausau.

Dr. Thomas J. Cox to Head Catholic Physicians Guild

Thomas J. Cox, MD* of Whitefish Bay was elected president-elect of the Catholic Physicians' Guild of Milwaukee at the organization's annual meeting December 11.

Dr. Cox, a family physician, will assume the office of president in December of 1972, succeeding John E. Sinsky, MD* of Wauwatosa who was installed as president.

Nicholas F. Damiano, MD,* Hales Corners, was reelected secretary–treasurer. Steve L. Chojnacki, MD,* Milwaukee, was elected to a three-year term on the board of directors.

Dr. Eckstam Green County Head

Eugene E. Eckstam, MD* of Monroe has been elected president of the Green County Medical Society. Other officers are: John R. Fuller, MD,* vice-president, and M. M. Qureshi, MD,* secretary–treasurer. William E. Hein, MD* was named a delegate of the group, with William L. Baker, MD* as alternate.

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Preventive Care for Poor Children

Free preventive medical care for children under Medicaid may be available in Wisconsin by next month if State Senate Bill 731 becomes law.

The addition of medical screening, diagnosis, and treatment benefits to federal programs for the medically indigent was authorized by Congress in 1967 and is to take effect February 7, 1972. State Senate Bill 731 would enable Wisconsin to add these services. The bill has been given a hearing and action is expected after the state legislature reconvenes January 18.

According to officials of the State Department of Health and Social Services, the program will initially cover only children under six. It is to be extended to all eligible children under age 21 by July 1, 1973.

The benefits are to include "early and periodic screening and diagnosis to ascertain physical and mental defects and treatment of conditions found." The program also includes "eyeglasses, hearing aids, and other kinds of treatment for visual and hearing defects, and at least such dental care as is necessary for relief of pain and infection and for restoration of teeth and maintenance of dental health."

These benefits have been available to children eligible for Group One Medicaid—the disabled, blind, and those under Aid to Families with Dependent Children. The new program will extend the coverage to children under Group Two Medicaid—those in families having severely limited finances.

Spokesmen for the United States Department of Health, Education, and Welfare have said that $20 million will be spent on the program in the current fiscal year. The tab will be $40 million in February 1973 and $200 million in February 1974.

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Medical History Talk at UW Union Feb. 9

A medical history seminar open to the public "On the Importance of Being Right—for the Right Reasons" will be given February 9 by Professor Robert Siegfried, Chairman of the University of Wisconsin Department of the History of Science. His topic will be scientific discovery for this, the third William Snow Miller Medical History Seminar sponsored this academic year by the UW Medical School's Department of History.

The 8 p.m. lecture will be held in room 109-A of the UW Union South. It will be preceded by a cash bar social hour at 6 p.m. and a dinner at 6:45 in room 202 Union South. Dinner reservations should be made by February 7 with the Department of the History of Medicine, 302 Medical Library, Madison 53706, and should be accompanied by a check to the UW Union for $4.25 per person.

The lecture series has recently been reorganized by the History of Medicine's new chairman, Guenter B. Risse, MD, PhD. Lester King, MD, senior editor of the JAMA will speak at the fourth lecture April 26.

Beloit Screens Sickle Cell Anemia

A mass, free testing for sickle cell anemia among the black community of Beloit was conducted January 9 in five locations. Cost of the community effort was set at $10,000. Jordon Frank, MD,* pathologist, explained characteristics of sickle cell anemia during a public meeting relating to the disease prior to the mass testing.

Medical Staff Officers Elected, Waukesha Mem.

Thomas E. Dugan, MD,* New Berlin, was reelected chief-of-staff, and Earl G. Schulz, MD,* Waukesha, was reelected vice-chief-of-staff by the Waukesha Memorial Hospital Medical Staff at the annual meeting held December 14.

A. M. Richter, MD,* Waukesha, was elected as at-large-member of the Staff's Executive Committee, and Jergen L. Barber, MD,* Waukesha, was elected as the Staff's representative to the Board of Trustees at the same meeting.

Dr. Richter and Dr. Barber's terms are for one year and the other two are three-year terms.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1971

1	American Board of Surgery Exams
4	Wisconsin College Health Association
7	SMS Commission on Safe Transportation
7	Dane County Medical Society Board of Trustees
7	Dane County Medical Society Public Relations Committee
7	Dane County Medical Society Special Meeting
7	Madison General Hospital Surgical Staff
7	Madison Urological Society
7	Madison Anesthesiology Society
9	Executive Committee, CES Foundation
9	Madison & Area Otolaryngologists Seminar
14	Dane County Medical Society Board of Trustees
14	Dane County Medical Society Regular Meeting
17	MEDIHC Operating Committee
18	Executive Committees of SMS Council & SMS Commission on Medical Care Plans
18	SMS Commission on Medical Care Plans
29	Board of Directors & Executives of Chartering Organizations, Wisconsin Association of Professions
29	Board of Directors, Health Care Review Corporation

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

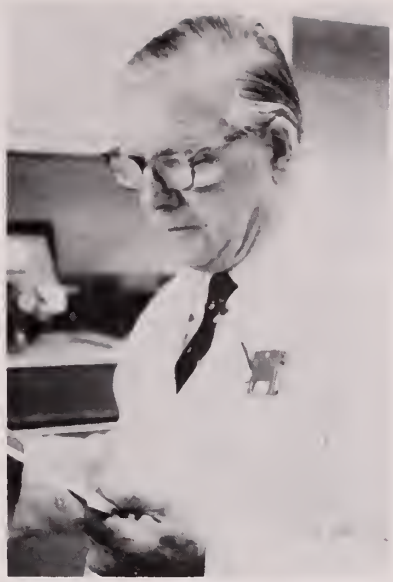
Dr. Frank Ellis, Noted Radiotherapist, Joins Medical College–Wis.

Frank Ellis, MD, has joined the faculty of the Department of Radiology, Medical College of Wisconsin, Milwaukee, as the new director of Radiation Therapy.

His assignments include directing the radiation therapy departments in both Milwaukee County General Hospital and the Veterans Administration Hospital, Wood.

An internationally known expert in the field of radiation therapy, Dr. Ellis retired as professor of radiation therapy at Oxford University, Oxford, England, in 1970, and since that time has been visiting professor at the University of Southern California School of Medicine in the Department of Radiation Therapy.

Dr. Ellis received his MD degree from Sheffield University, Sheffield, England. His professional background includes medical directorship of centers in Sheffield, the London Hospital, and Oxford, and directorship of the Radiotherapy Department of Churchill Hospital in Oxford, England.



Dr. Ellis

His major area of research interest is in time–dose fractionation problems and the automation of radiotherapy.

Norbert G. Bauch, MD*

. . . a member of St. Michael Hospital (Milwaukee) medical staff for 22 years, has 16 medical school graduates working with him in the newly established Family Practice specialty at the hospital. The three-year program includes work in the newly established St. Michael Family Care Center. Doctor Bauch is director.

Albert Kniaz, MD*

. . . has been named the first full-time medical director of the St. Michael Hospital Mental Health Center in Milwaukee. The Center was formerly known as the mental health clinic.

Edgar S. Gordon, MD*

. . . Madison, professor of medicine and chief of the metabolism and endocrinology division of the University of Wisconsin, recently spoke on "Diabetes and Heart Attacks—Two Interrelated Diseases" at the University of Wisconsin–Whitewater.

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Peter S. Karofsky, MD

. . . Madison, has joined the Jackson Clinic in the department of pediatrics and adolescent medicine. He completed his pediatric training at the University of Wisconsin and served two years with the U.S. Air Force. He served as a fellow in ambulatory pediatrics at the Indiana University Medical School and also is a clinical instructor at the University of Wisconsin Medical School.

Max M. Smith, MD*

. . . Madison, recently was featured in "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Smith graduated from the University of Wisconsin Medical School in 1944, and in 1945 served with the Army as a regimental surgeon in the European theater and studied and graduated from the University of Vienna Graduate School of Surgery. Doctor Smith took his psychiatric residency at the University of Wisconsin Medical School, serving as chief resident and also as an instructor in the department of neuropsychiatry. He helped organize the Wisconsin Psychiatric Association and later served as its president. Doctor Smith is chief of staff at St. Mary's Medical Center, Madison, and also is an assistant clinical professor of Psychiatry at the University of Wisconsin Medical School.

G. Douglas Reilly, MD*

. . . Menasha, Stanley Berlow, MD and Curtis R. Weatherhogg, MD,* both of Madison, recently were elected to fellowship in the American Academy of Pediatrics.

Andrew J. Krapohl, MD*

. . . Marinette, recently left the medical staff of the Marinette Medical Clinic to enter Horace H. Rackham graduate school at the University of Michigan. Doctor Krapohl is a fellow in the American College of Obstetricians and Gynecologists and received his medical degree from the University of Michigan School of Medicine. In addition to his studies at the University of Michigan, Doctor Krapohl will work in Jackson with a health organization which provides medical services to the underprivileged and indigent residents.

CONTRIBUTIONS—CES FOUNDATION

November 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for November 1971:

Nonrestricted

State Medical Society Members	Voluntary contributions of 10 MDs
Gene and Margaret Hoeschler	Memorial: James C. Fox, MD
Elnora Hayes Johnson	Memorial: Alex Kohn
Dr. and Mrs. Thomas J. Doyle	Memorial: James W. McGill, MD
State Medical Society	Memorial: G. H. Smullen, MD
State Medical Society	Memorial: James W. McGill, MD
State Medical Society	Memorial: E. T. Sheehan, MD
State Medical Society	Memorial: M. G. Peterman, MD
State Medical Society	Memorial: R. T. Sproule, MD
State Medical Society	Memorial: E. F. Barta, MD
State Medical Society	Memorial: G. H. Stevens, MD
State Medical Society	Memorial: J. W. Lowe, MD

Tormey Memorial Fund

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State Medical Society Members	Voluntary contributions of 3 MDs

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W. W. Hildebrand Memorial Account

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Danforth Memorial Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

Barbara Scott Maroney Memorial Fund for Research on Diabetes

H. B. Maroney, II	Memorial: W. D. Stovall, MD

Dr. Grinde Bell Account

C. H. Crownhart	Contribution

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continued on next page

Dr. David J. Carlson Elected President of Milwaukee County Medical Society

The Medical Society of Milwaukee County officers for 1972 were announced December 9 at that Society's annual meeting.

Those who took office January 1 are: David J. Carlson, MD,* president; Jules D. Levin, MD,* president-elect; and Barney B. Becker, MD,* secretary–treasurer. Retiring president, Henry F. Twelmeyer, MD,* became a director. At its meeting, the Society also presented a special citation to Eugene Collins, MD,* a past president and retiring director.

The Milwaukee Society marked its 125th anniversary at the annual meeting. Citations in honor of the occasion were presented by Milwaukee County Executive John L. Doyne and the American Medical Association. The Milwaukee County citation praised the county society "for your 125 years of medical service to your fellow man and to your community" and congratulated the 1,500 physician members. State Medical Society President George A. Behnke, MD,* Kaukauna, was on hand to personally congratulate the Milwaukee Society on its 125th anniversary.

In his presidential address, Dr. Carlson noted that after 125 years "the purposes of The Medical Society of Milwaukee County have remained essentially unchanged: to provide the best possible medical care by promoting the highest standards of professional skills; to protect the public from quackery, incompetence, and dishonesty; to promote and aid the professional advancement of its own members."

At the meeting the Milwaukee Society presented its second annual press award to Paul Hayes, environmental reporter for the MILWAUKEE JOURNAL. The award is given in recognition of outstanding journalism in the field of medicine or a related health area.

Helen Crawford Portrait Given to UW–Madison

A portrait of Miss Helen Crawford, formerly of Madison, retired head of the Middleton Medical Library and a UW–Madison medical school faculty member for 26 years, was presented to the school November 6.

The ceremonies took place at the University of Wisconsin Medical Alumni Association annual fall meeting.

CES FOUNDATION CONTRIBUTIONS *continued*

Mr. & Mrs. Charles H. Johnson, Mr. & Mrs. James Conrad, Dr. & Mrs. W. E. Meisekothen, Mr. & Mrs. LeVerne M. Kirking, Dr. & Mrs. C. E. Schram, Mrs. Dorothy Haines & Sons, Jeff & Randy, Dr. & Mrs. C. A. Fosmark, Monona Grove Clinic, S. C., Mr. & Mrs. Arnold Byrne, Mr. & Mrs. Robert Huegel, Dr. & Mrs. Lindley V. Sprague, Mrs. Joseph LaCrosse, Mr. & Mrs. Roger Altpeter, Dr. & Mrs. W. F. Donlin, Mr. & Mrs. James R. Mitchell, Sadie Chapin, Mrs. Raymond Kelly, Mr. & Mrs. Norman T. Baillies, Dr. & Mrs. Ben Brindley, Employees, Directors & Officers of Security Marine Bank of Madison, Mr. & Mrs. Ronald Blomberg, Miss Mary Jo Reznichek, Mr. & Mrs. Ronald J. Glowac, St. Mary's Hospital Staff Fund—Madison, Mr. & Mrs. Arthur Krueger, Dr. R. C. Herrin, Mr. & Mrs. Irving Gerhardt and Scott, Mr. & Mrs. Charles Swanson, Mr. & Mrs. John Wright, Bergmann's Inc., Mr. & Mrs. Joseph Pollack, Mrs. Orin Uvas, Miss Phyllis Lee, Mr. & Mrs. Mack Mitchell, Dr. & Mrs. M. T. Morrison, Miss Helinda Raemisch, RN, Mr. & Mrs. Leo Fix, Mr. & Mrs. John DeBeck, Dr. & Mrs. George Hank, Mrs. Thelma Lathrop, Mr. & Mrs. Harold House, Mr. Gerald L. Gulseth, Mr. & Mrs. Rutland Goff, Mr. & Mrs. Walter Gilomen, Woman's Auxiliary to the Dane County Medical Society, Mr. & Mrs. Earl V. Rupp, Mr. & Mrs. Albert Lerdahl, Mr. & Mrs. Alden Ross & Family, Royal Order of Jesters Ct. #126, Mr. & Mrs. James L. Casey, Jr., Mr. & Mrs. W. G. Beduhn, Mr. & Mrs. Edward Persen, Dr. & Mrs. D. O. Simley, V. M. Nordholm, MD, D. L. Nelson, MD, Mr. & Mrs. John Lythjohn, Madison Lodge #5 F. & A.M., Mrs. George L. Reznichek, Mr. & Mrs. John Krueger, Mr. & Mrs. Jim Mavis, Mrs. Art Paul, Mrs. E. Udclair, Mr. & Mrs. Frank D. Hamilton, Mr. & Mrs. Robert Stephens, Mr. & Mrs. Kermit Frater and Family, Mr. & Mrs. Norman Wang, Dr. & Mrs. Thomas H. Peterson, Mr. & Mrs. Robert Cheetham, Alice J. Orshall, Mr. & Mrs. D. E. Valentine & Family, Dr. & Mrs. John E. Gainor, Dr. & Mrs. E. E. Skroch & Family, Mr. & Mrs. C. L. Mattes, Mr. & Mrs. R. E. Sorenson & Family, Mr. & Mrs. Thomas Maloney & Family, Mr. & Mrs. Wayne Matthews & Family, Mr. & Mrs. Charles O'Hara & Family, Mr. & Mrs. Randy Bernard & Family, Mrs. Martin Zanna, Mr. & Mrs. Shephen & Family, Mr. & Mrs. John Reznichek, Mrs. Angela Tripp, Family & Friends of C. G. Reznichek, MD, and A. P. Schoenenberger, MD ---------- Memorial: C. G. Reznichek, MD

Arthur A. Cantwell, Jr., MD*

. . . Shawano, a member of the Cantwell–Peterson Clinic staff since 1968, recently became a diplomate of the American Board of Surgery.

B. P. Choudhuri, MD

. . . Menomonie, recently joined the medical staff of the Red Cedar Clinic. Prior to joining the clinic staff, he was a surgical assistant at St. Luke's Hospital in Milwaukee. He received his medical degree from Calcutta Medical College, Burma, India, and did postgraduate surgery at the Royal College of Surgeons in Edinburgh. He served his internship and residency in Derby and New Haven, Conn., and was a specialist surgeon in British Honduras for two years.

Ervin F. Kuglitsch, MD*
John A. Leschke, MD*

. . . Greendale and Oshkosh, respectively, recently were certified as Fellows of the American College of Anesthesiologists.

Richard H. Siedenburg, MD*

. . . Jefferson, has been reelected chief of staff of Fort Atkinson Memorial Hospital. Other officers are: MDs Frank V. Beran,* Fort Atkinson, vice-chief of staff; F. C. Yao,* Whitewater, chief of surgery; D. E. Bates,* Fort Atkinson, chief of obstetrics, and Manfred Effenhauser,* Lake Mills, secretary–treasurer.

Carl J. Saggio, MD

. . . Fond du Lac, recently joined the medical staff at Associated Physicians, Fond du Lac. A graduate of Marquette University School of Medicine (now The Medical College of Wisconsin), he worked for a short time as an emergency room physician at Columbia Hospital, Milwaukee, before entering the United States Army. He was a battalion surgeon in Vietnam for one year and prior to joining Associated Physicians, he spent eight months at Ft. Gordon, Ga., where he was chief of the medical examination service.

Frank C. Stiles, MD*

. . . Monroe, recently was appointed to the Council on Pediatric Practice of the American Academy of Pediatrics.

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The following general rules are applicable to advertisements of medicinal preparations, apparatus or physical appliances or other products for therapeutic or diagnostic purposes or for which therapeutic, diagnostic or health claims are made:

1. The advertiser may be required to submit evidence or data in support of the usefulness of the product and the validity of the claims. The appearance of one or several papers may not necessarily be considered sufficient evidence and other data may be required.
2. Medicinal preparations containing two or more active ingredients will be considered only if in the opinion of the Advertising Committee of the Bureau there is a logical rationale for the inclusion of each active ingredient, and if a statement of the active ingredients is included in each advertisement.
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2. Unfair comparisons and disparagement of a competitor's goods will not be allowed.
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1972 ANNUAL MEETING

State Medical Society of Wisconsin

MAY 9–11

Hotel Sheraton–Schroeder; Holiday Inn Central;
Downtowner Motor Inn
Milwaukee

Highlights of Scientific Program

THEME: INFECTIOUS DISEASE—ACTION AND REACTION—1972

Tuesday, May 9

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P.M. Anesthesia, Ophthalmology, Otolaryngology, Orthopedics, Physical Medicine & Rehabilitation, Surgery

trends

The Wisconsin Regional Medical Program, Inc.

JANUARY, 1972

Pull Together Delivery System With Education Centers and HMO's — Dr. Margulies

RMPS Head Tells Wisconsin RMP Advisory Group of "Future"

Health is a community affair. People have begun to believe that not because health has suddenly become a deep concern of this country or because health is going to be a major political issue but rather because there is an emulation of a new kind of spirit emerging in this country that says "we who are consumers have a voice in the decision making process from which we have been previously exempt."

The role of the consumer and the "simplicity rather than complexity" of the future health care delivery system were discussed by Dr. Harold Margulies, Director, Regional Medical Programs Service, HEW, Washington, at a recent meeting of the Regional Advisory Group of the Wisconsin RMP.

"There will occur in this country, in the coming years, a consistent effort to pull together the health care delivery system so it makes some sense," Dr. Margulies said. "Those who will be attached include the university health science center, medical schools and so forth, not as separate institutions, but rather as a point of responsibility in meeting the health needs of the community.

"Private and public insurance systems will be looked at carefully, regulated where necessary, made public property when appropriate,"

Dr. Harold Margulies, Director, Regional Medical Programs Service, HEW, Washington, was interviewed after speaking to the Wisconsin RMP Regional Advisory Group.

he continued. "The quality of medical care will be measured, made a matter of internal scrutiny, external scrutiny, and in a relatively short time, public scrutiny. There will be a determination that the cost of medical care will flow in a direction of community priorities, not physician priorities and not hospital priorities. There will be a pulling together of all activities in which we are involved, federal, state and private so the total point at issue, improved health care, will be identified and appropriately served."

Dr. Margulies continued saying that this tying together of activities to improve the health care delivery system could be brought about with the establishment of Area Health Education Centers (AHEC) and Health Maintenance Organizations (HMO).

With regard to AHEC's, Dr. Margulies said he was talking about a focal point of activity, a place in the community, "which decides it would like to bring together its resources, educational, care institutions, private institutions, out-patient departments, private practice, as much as possible for a common purpose. That common practice would have to be predicated on the acceptance of the idea that services which are now being provided could be improved and that the relationship between levels of education and service is currently unsatisfactory and that this level should be redesigned around one goal — the improvement of health service, and that there is, in fact, no other goal at any level of medical education excepting service."

Dr. Margulies said that Regional Medical Program has been asked to take on the responsibility in HEW for establishing methods for monitoring the quality of care and that his department has accepted this responsibility. He noted that the establishment of these methods was essential if AHEC's and HMO's were to function effectively and that new dimensions in the delivery of health care had to be persued if improvement was to be made. He added that the HMO's responsibility will be to establish a consistent method of maintaining medical care for a patient who has once been seen or who needs to be seen by a physician.

$100,000 in Contract Offerings Available

The Wisconsin RMP is making available to all interested parties a series of contract offerings amounting to $100,000 which is expected to help alleviate some of the health care problems presently confronting the Region.

More than 16,000 brochures were mailed in December to physicians, nurses, medical schools, clinics, hospitals, nursing homes, health planning agencies, health insurance carriers and other interested parties. Approximately 50 inquiries have been received to date.

Three contract offerings are being made:

Sharing Health Resources — This contract requires two or more health organizations to develop a plan for sharing of services, facilities and/or manpower with the purpose of reducing health care costs while maintaining or improving quality patient care.

Health Services for Medically Deprived Areas — This contract should propose the development of a health care delivery system in areas which are medically deprived — no physician communities.

Pre-Admission Testing — Propose a plan to determine the effect on hospital costs and quality of care through patient testing prior to and after admission.

Dr. Paul C. Tracy, Associate Coordinator for Planning and Development noted that proposals seeking funds for the development of one or more contract offerings must be completed and received by his office before March 1.

RMP-CHP Relationships

By John S. Hirschboeck, M.D.
Coordinator, Wisconsin Regional Medical Program

Several years ago we occasionally heard that Regional Medical P grams and Comprehensive Health Planning were incompatible federal p grams on a collision course, or that one would overtake the other. Effo to merge the programs failed in the 91st Congress, and, in our opini their continuing independence has been beneficial to both because th functional roles are now more clearly defined.

CHP is concerned principally with planning resources needed to i prove the delivery of health services, whereas RMP is concerned pr cipally with developing and implementing the programs which are ide fied through the planning process. It is evident, therefore, that one co plements the other. The idea that there is wasteful duplication of eff is a fiction which arises from the notion that both are concerned exclusiv with health planning.

DRUG RESEARCH REPORTS, widely circulated newsletter, contin to emphasize this assumed conflict and has singled out Wisconsin as example, erroneously inferring that Governor Lucey found it expedient merge CHP and RMP under the newly-created Health Policy and Plann Council. Even though the Wisconsin RMP and CHP have a membersl on the Council, both maintain their independence and work in conc with other representatives of health care.

The Wisconsin RMP, the Bureau of Comprehensive Health Planni and the Areawide Health Planning Agencies have, from the beginni worked together in harmony and support each other in their areas strengths and competencies.

A recent example of collaboration, one of several, is described elsewh in this issue of TRENDS. The Wisconsin RMP provided technical ass tance to Comprehensive Health Planning Agency of Southeastern Wisc sin in assessing the desirability of endorsing an expansion of a card vascular surgical resource in southeastern Wisconsin. The study provid the Comprehensive Health Planning Agency of Southeastern Wiscon with valuable information and at the same time gave the Wisconsin RM information which will be valuable in improving cardiovascular servi elsewhere in Wisconsin.

Wisconsin RMP Assists CHP in Evaluation

At the request of the Comprehensive Health Planning Agency for Southeastern Wisconsin (CHPASEW) the Wisconsin RMP evaluated the need for a 185-bed, $18.4 million expansion program request of St. Luke's Hospital, Milwaukee. The hospital asked CHPASEW for endorsement to expand its heart surgery, intensive care and intensive respiratory care facilities. Before making a final decision as to meeting the comprehensive health plan needs of the community, CHPASEW asked the Wisconsin RMP to make a professional appraisal of the facility as to whether or not, from the practitioners viewpoint, the planned facility includes all of the current technical and scientific assistance necessary — equipment and manpower — to carry out its objective. At its January meeting of its Board of Directors, CHPASEW voted to approve $16.8 million of the $18.4 million requested by the hospital.

Merton E. Knisely, left, and Mrs. Rob Dineen, CHPASEW board member a member of the Wisconsin RMP Regio Advisory Group discuss a section of lab facility at St. Luke's. Charles Lemke, Wisconsin RMP Director of Ev uation, is at the right.

MP's Colposcopy Project Reduces Uterine Cancer Test Costs 93%

.lmost everything people are try- to do — decrease the cost of lical care, bring the advance- ıts of medical science and tech- ɔgy to the community level for lementation, keep the health welfare of the patient foremost nind — is exemplified by the re- t success of the Wisconsin Re- ıal Medical Program's Colpos- y Project.

Evaluation of the project has wn that the cost of a uterine cer examination, done as a re- of an abnormal Papanicolaou AP) smear, can be reduced as ch as 93 percent.

The project, under the direction Dr. Adolf Stafl of the Medical lege of Wisconsin, is part of sconsin Regional Medical Pro- ım's Gynecologic Malignancy gram under the direction of Dr. ı M. Peckham, Chairman, De- tment of Gynecology and Ob- rics, University Hospitals, Mad- ı, and Dr. Richard F. Mattingly, ıirman, Department of Obstet- and Gynecology, Medical Col- e of Wisconsin. It is a good ex- ple of how Regional Medical grams are succeeding in bring- the advancements of technology l science to the local level for eral implementation in an effort keep the costs of medical care at ıinimum and patient care at an imum.

Colposcopy is a procedure used the detection of uterine cancer owing a PAP test. If the PAP shows an indication of being ıormal, the colposcopic examina- ı is used in place of a diagnostic ıization procedure. It is esti- ted that 750 cases of uterine ıcer will be found in Wisconsin in 1972 and approximately 43,000 cases will be found in the United States.

According to Dr. Stafl, the introduction of the colposcopic procedure in the examination of women suspected of or having cancer of the uterus will enable more women to be examined, by more physicians, in more areas of Wisconsin, at a greatly reduced cost which will lead to the early detection and possible elimination or control of the disease.

"Through the use of Wisconsin Regional Medical Program funds, I have been able to train other physicians in Wisconsin in the proper use of the method so they can perform the procedure on a regionalized basis," Dr. Stafl said, "The equipment is relatively simple. The most important part of the procedure is knowing what to look for. This is what takes the time and training."

LEFT — Dr. Stafl displays the use of the light beam which is an integral part of the equipment. RIGHT — Dr. Stafl explains the colposcopy procedure to Dr. Stephen A. Massick, a resident at Milwaukee County General Hospital, during the examination of a patient.

Dr. Stafl has helped train six physicians through funding from the Wisconsin Regional Medical Program, who have become highly proficient in utilizing the technique. They are located at St. Francis Hospital and the Gunderson Clinic, La Crosse; Marshfield Clinic, Marshfield; St. Elizabeth Hospital, Appleton; and University Hospital, Madison. He is presently training several physicians at Milwaukee County General Hospital who are serving their residency.

"Several of the hospitals have been able to develop a cost analysis which reflects the savings to both the hospital and the patient," Dr. Stafl continued. "St. Francis Hospital at La Crosse estimated that the average cost of a conization is approximately $493, $319 for the hospital, $24 for anesthesiology and $150 for the surgeon," he added. "With the introduction of the colposcopic procedure, the total cost was reduced to only $35."

Dr. Wanir C. da Costa at St. Francis Hospital, La Crosse, who figured the cost estimate also noted a value, that could not be included, was in the great reduction of time and discomfort on the part of the patient.

"In the past, the patient undergoing a diagnostic conization was hospitalized for two or three days, underwent surgery and had to make arrangements outside the hospital for such things as the care of her children," Dr. da Costa said. "Since we have been using the colposcopy technique rather than the conizations, the patient is admitted as an outpatient and in a matter of minutes, can return home to her family without undergoing surgery and without having a great degree of discomfort."

"The PAP test is still the most practical and most accurate of the cervical cancer detectors," Dr. Stafl said. "Screening of all women using the colposcopic technique could increase the diagnostic accuracy of cervical cancer. But, so far, the number of physicians trained in colposcopy is not sufficient to carry out such a program. Therefore, the main application of colposcopy is in the clinical diagnosis of patients with abnormal cytology. Our results from satellite clinics show that colposcopy can detect some preinvasive carcinoma in women whose cytology examination was just atypical, not suspect or positive."

Dr. Stafl, born and educated in Prague, Czechoslovakia is one of the few physicians in this country with the training and expertise in the use of colposcopy — a technique used for many years in European countries. With the completion of the project of the Wisconsin Regional Medical Program and the training of an additional six physicians in Wisconsin, the Wisconsin Region can boast of having the largest percentage of the nations physicians trained in colposcopy.

Dr. Stafl and Dr. Per Kolstad, Chief, Radium Hospital, Oslo, Norway, recently completed a book, *Atlas of Colposcopy*. The book is expected to be available in the United States in the next several weeks.

PEDE, McAULIFFE Join Wisconsin RMP as Liaison Staff

The appointment of new staff members has provided the Wisconsin RMP with a capability of improving its relationship with the many communities in the Region, according to Dr. John S. Hirschboeck, Wisconsin RMP Coordinator.

James E. Pede has been appointed Associate Coordinator for Regional Liaison and Edward J. McAuliffe, Southeastern Wisconsin Regional Representative.

Pede, 38, received his master's degree in health administration from Washington University School of Medicine, St. Louis. He was Administrative Resident at St. John's Mercy Medical Center, Creve Coeur, Mo., and served as the administrator of hospitals in South Dakota and Montana. Most recently, he was the assistant administrator of Arlington Community Hospital, Arlington, Texas.

As Associate Coordinator for Regional Liaison, Pede will be responsible for assisting hospital administrators and providers of health care in the improvement of health care delivery at the community level in conjunction with other health agencies.

McAuliffe, 56, of New Berlin, Wis., was formerly associated with the Wisconsin Heart Association as the Director of Field Services and

James E. Pede *Edward J. McAuliffe*

the Director, Campaign Department.

He attended Western Reserve University, Cleveland, and has held several positions with pharmaceutical firms prior to joining the heart association in 1965.

"With the appointments of Pede and McAuliffe, we hope to better understand the health care problems at the community level," Dr. Hirschboeck said. "Charles Clark will continue to cover the northern portion of Wisconsin and Roy Ragatz the southern section of the state. With the kind of 'personalization' we want to build into our program and with the calibre of people in the field there is little doubt in my mind that we will be able to assist in many more ways than in the past in the development of a system that will cut costs, save lives and provide the physician and nurse with a better capability of utilizing new methods and techniques in their daily work."

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1972 WISCONSIN

Feb. 17: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Immediate Care of Acute Stroke" and "Current Management of Diabetic Keto-acidosis and Coma," at St. Marys Hospital Medical Center, Madison.

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Feb. 29, Mar. 7, 14, 21, 28, and Apr. 4: Scientific teaching program of interest to family physicians, St. Joseph Hospital, Dodgeville, except last session at Dodge Point Country Club. Presented by South West Chapter of Wisconsin Academy of Family Physicians with cooperation of Fourth Councilor District and CES Foundation of the State Medical Society of Wisconsin.

Mar. 4: Fourth Annual Southeastern Wisconsin Cancer Conference—*A New Look at Lymphomas,* Ramada Sands Inn, Milwaukee. Info: SWC Conference, % St. Mary's Hospital, 2320 North Lake Drive, Milwaukee, WI 53211.

Mar. 13, 22, and 23: 1972 Farm Accident Symposium, sponsored by State Medical Society of Wisconsin; Downtowner Motel—Green Bay, Holiday Inn—Eau Claire, and Holiday Inn No. 2—Madison, respectively.

Mar. 15: Symposium on Aerosol Abuse, Heritage House, Madison. Sponsored by Wisconsin Dangerous Substance Control Council, Room 523, 1 West Wilson St., Madison, WI 53702.

Mar. 15: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Current Management of Rh ve Pregnant Patient Before and After Delivery" and "Current Management of the Newborn Who Becomes Jaundiced in the First 24 Hours," at St. Marys Hospital Medical Center, Madison.

Mar. 22: Aaron Brown Memorial Lecture sponsored by Phi Delta Epsilon fraternity, Medical College of Wisconsin, Milwaukee. Visiting Professor in Surgery: John Beal, MD, PhD, professor and chairman, Department of Surgery, Northwestern University School of Medicine, Chicago, Ill., and chairman of the American Board of Surgery. Major address: *The Influence of Board Certification on Graduate Education in Surgery.*

Mar. 23–25: *Learning Disabilities in Children,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Mar. 31, Apr. 1: Seventh Annual Teaching Days in Sports Medicine, University of Wisconsin Department of Postgraduate Medicine, Wisconsin Center, Madison.

Mar. 31–Apr. 1: Midwest Chapter, College of Sports Medicine Meeting, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 13–15: *Advances in Pediatric Radiology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–10: Wisconsin Clinic Managers Association, Downtowner Motor Inn, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Applied Genetics for the Clinician Conference, Wisconsin Center, Madison. Info: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

1972 NEIGHBORING STATES

Feb. 15–18: Four-day refresher course for family practitioner of medicine, University of Iowa Health Center. Info: Director, Office of Medical Education, Office of the Dean, University of Iowa, Iowa City, Iowa 52240.

Mar. 7–11: Convention '72, combined meeting of the Clinical Conference of Chicago Medical Society and Illinois State Medical Society's Annual Meeting, Conrad Hilton Hotel, Chicago, Ill.

Mar. 16–17: Female Reproductive Physiology Symposium, Rockford Memorial Hospital, Rockford, Ill. Info: Dr. Ronald Burmeister, 2300 North Rockton Ave., Rockford, Ill. 61103.

Apr. 17–19: 2nd Annual Great Lakes Health Congress—Health Industries Association, Mid-America Assembly, and Tri-State Hospital Assembly. McCormick Place-on-the-Lake, Chicago, Ill. Info: Great Lakes Health Congress, 400 North Michigan Avenue, Chicago, Ill. 60611. (Phone: 312/321–0317)

Apr. 27–28: Region III Seminar of American Foundation for the Blind, Pheasant Run Inn, St. Charles, Ill. Seeks to carry forward services in such areas as medical and health, social welfare, rehabilitation, home assistance, recreation and transportation . . . to improve the economic and social status of the nation's aging blind population.

May 10–13: Postgraduate course on Fractures and Other Trauma, by Chicago Committee on Trauma of American College of Surgeons, Sheraton–Chicago Hotel, Chicago, Ill.

1972 AMA

Mar. 16–17: 25th National Conference on Rural Health, AMA Council on Rural Health, St. Francis Hotel, San Francisco, Calif.

Mar. 22–25: National Congress on the Quality of Life, AMA Board of Trustees in cooperation with 20 governmental and volunteer agencies, Palmer House Hotel, Chicago, Ill.

Apr. 6–8: Sixth National Congress on the Socio-Economics of Health Care, Ft. Lauderdale, Fla.

Apr. 24–25: Congress on Environmental Health, The Biltmore Hotel, Los Angeles, Calif.

June 18–22: Woman's Auxiliary 50th Anniversary Convention, St. Francis Hotel, San Francisco, Calif.

June 18–22: AMA Annual Meeting, St. Francis Hotel, San Francisco, Calif.

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton-Schroeder, Milwaukee.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

For listing of other meetings see the **Journal of the American Medical Association.**

Continuing Education Courses for Physicians for period Sept. 1, 1971 through Aug. 31, 1972 appeared in *JAMA*, Aug. 2, 1971.

1972 Farm Accident Symposium

The State Medical Society of Wisconsin is sponsoring a farm accident symposium similar to one held in La Crosse in 1970, under auspices of its Committee on Occupational Health, Commission on Health Information.

The same program will be presented on three dates in separate locations. On March 13 it will be given in the Downtowner Motel, Green Bay; March 22, Holiday Inn, Eau Claire; and March 23, Holiday Inn No. 2, Madison.

Donald V. Jensen, extension safety specialist, Department of Agricultural Engineering, University of Wisconsin, Madison, is chairman of the morning session. He will give the welcoming remarks on "Wisconsin Farm Accident Study." "Some Representative Farm Accidents" will be presented by Sigurd B. Gundersen, Jr., MD, Surgical Department, and Allen G. Brailey, Jr., MD, Department of Internal Medicine, both of the Gundersen Clinic, La Crosse. Discussion will follow.

The afternoon session will be conducted by Arnold Cordes, consultant for agricultural education, State Department of Public Instruction, Madison. The topics and speakers are: "Need for Chemicals in Agriculture," by Glenn S. Pound, dean and director, College of Agriculture and Life Sciences, UW, Madison; "The Safe Handling of Pesticides," by Ronald E. Doersch, extension weed control specialist, College of Agriculture and Life Sciences, UW, Madison; and "Safety—The Fifth Dimension," by L. Hodges, director of research and technical service, J. I. Case Company, Racine. These lectures will be followed by a panel of speakers and local participants in a discussion with the audience.

Attendance by area farmers is encouraged.

A registration fee of $3.00 per person includes a luncheon. Checks payable to: State Medical Society of Wisconsin, P.O. Box 1109, Madison, WI 53701.

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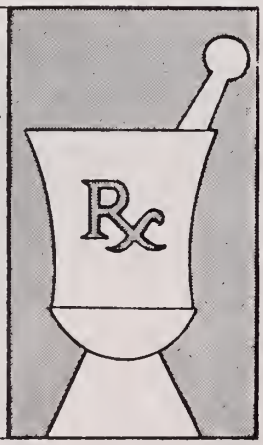

Visiting Professor in Surgery—Milwaukee

On March 22 John Beal, MD, PhD will visit the Medical College of Wisconsin to act as Visiting Professor in Surgery and deliver the Aaron Brown memorial lecture sponsored by the Phi Delta Epsilon fraternity.

Doctor Beal is professor and chairman of the Department of Surgery, Northwestern University School of Medicine, Chicago, Ill., and chairman of the American Board of Surgery.

In the morning at 10.00 o'clock, Doctor Beal will be the guest of honor at a Rocking Chair Conference in the King Conference Room of Milwaukee County General Hospital.

His major address will be given between 12:30 and 1:30 in the Coffey Auditorium of MCGH. It is entitled, "The Influence of Board Certification on Graduate Education in Surgery."

A Surgical Conference will be held from 4:00 until 5:00 in the King Conference Room of MCGH.

Medical students, house officers, and faculty of the affiliated hospitals, Medical College of Wisconsin, and all physicians of the greater Milwaukee area, are welcome to participate in these activities.

Scientific Program for Family Physicians

A teaching program of interest to family physicians has been arranged by the South West Chapter of the Wisconsin Academy of Family Physicians with cooperation from the Fourth Councilor District and the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

The program will consist of six sessions on different dates, on Tuesday evenings from 7:30 to 9:30 on February 29, March 7, 14, 21, and 28 at St. Joseph's Hospital in Dodgeville, and on April 4 at the Dodge Point Country Club. This last session will begin with a preprandial hour from 6:00 until 7:00 followed by dinner and the program.

The program follows:

Feb. 29: Gordon V. Marlow, MD, proctologist, Madison—*Pitfalls of Proctology* and *Anal Fissures, Fistulas and Hemorrhoids.*

Mar. 7: F. E. Mohs, MD, clinical professor, University of Wisconsin Medical School—*Chemosurgery for Microscopically Controlled Excision of Skin Cancer.*

Mar. 14: James M. Huffer, MD, assistant professor, UW Medical School—*Pediatric Problems of Lower Extremities.*

Mar. 21: Gordon Davenport, MD, associate professor, UW Medical School—*Current Concepts of Burn Care* and other selected subjects of interest to the family physician.

Mar. 28: Robert J. Corliss, MD, clinical professor, UW Medical School—*Electrocardiography of Interest to the Family Physician.*

Apr. 4: A. P. Schoenenberger, MD, associate clinical professor of urology, UW Medical School—*Urology of Interest to the Family Physician.*

The speakers plan to use films, slides, x-rays, and the like.

Application is being made for 12 hours of prescribed credit by the Academy of Family Physicians.

Registration fee is $25.00 for the six sessions, not including preprandial and dinner accommodations at the last session. Contact W. D. Hamlin, MD, Mineral Point, WI 53565.

SE Wisconsin Cancer Conference

The 4th Annual Southeastern Wisconsin Cancer Conference is scheduled for March 4 at the Ramada Sands Inn in Milwaukee.

continued on page 10

fotos/72

STATE MEDICAL SOCIETY PHOTOGRAPHY CONTEST

NNING
OTOGRAPHS
RECEIVE AWARDS
D WILL BE DISPLAYED
THE ANNUAL MEETING

OPEN TO ALL MEMBERS OF THE STATE MEDICAL SOCIETY

Contest rules have been simplified to make it easier to enter your photographs.

All photographs entered should be mounted in the form in which entrant would like his prints to be exhibited. Mounted pieces should not exceed 16 inches by 20 inches. No frames will be accepted.

Prize winning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

A maximum of 10 prints may be entered by each entrant. All entries must be at the State Medical Society headquarters in Madison by April 24, 1972.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

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MEDICAL MEETINGS *continued*

Having as its theme, *A New Look at Lymphomas,* the conference will be highlighted with a panel discussion at 12:00 noon followed by a luncheon and discussion at 1:00.

Moderator of the panel will be Frederick W. Madison, MD of Milwaukee. Panelists include the four guest lecturers below and Bertram H. Dessel, MD and Anthony V. Pisciotta, MD of Milwaukee.

The guest speakers are as follows:

Robert J. Lukes, MD, professor of pathology, University of Southern California School of Medicine, Los Angeles.

M. Vera Peters, MD, senior radiotherapist at Ontario Cancer Institute Incorporating Princess Margaret Hospital, Toronto, Canada.

Vincent T. De Vita, MD, chief, Medicine Branch, National Cancer Institute, Bethesda, Md.

Ralph E. Johnson, MD, chief, Radiation Branch, National Cancer Institute, Bethesda, Md.

While there is no fee for the conference, there is a charge of $5.00 per person for luncheon tickets. Checks payable to SE Wisconsin Cancer Conference. Mail to: Southeastern Wisconsin Cancer Conference, % St. Mary's Hospital, 2320 North Lake Drive, Milwaukee, Wisconsin 53211.

Four hours of elective credit by the Academy of Family Physicians will be allowed.

Sponsoring organizations are: Columbia, St. Joseph's, St. Mary's, and St. Michael hospitals, Milwaukee and Wisconsin Divisions of American Cancer Society, and the Medical College of Wisconsin. Joseph J. Gramling, MD is program chairman.

Teaching Days in Sports Medicine—Madison

The Seventh Annual Teaching Days in Sports Medicine at the University of Wisconsin, Madison, will be presented March 31 and April 1 at the Wisconsin Center, Madison.

The second day will feature a combined meeting with the Midwest Chapter of the American College of Sports Medicine. Members of the College and Wisconsin researchers will present in the afternoon seminar on April 1, seven research papers dealing with Marathon Running, Function of the Heart After Surgery, and Functions of the Lung in Health and Disease at Sea Level and at Altitude.

Panel discussions on the Role of the High School Trainer, Resuscitation on the Field and in the Stands, Girls and Women in Sports, and the Use and Abuse of Things in Sports will feature the first day and a half of the conference.

The popular session of taping of the ankle and the knee will return in the opening session of the meeting as usual!

Further info: Department of Postgraduate Medicine, 610 North Walnut Street, Madison, WI 53706.

National Conference on Human Values & Cancer

A National Conference on Human Values & Cancer will be held at the Regency Hyatt House, Atlanta, Ga., on June 22–24. The conference, unique in concept, is intended to present the total problem that surrounds the cancer patient, both adult and children. From this meeting, it is hoped solutions of major proportions will result, assisting all concerned.

Members of the medical and related professions, and other individuals concerned with the cancer patient are invited to attend the conference. There is no registration fee. Preregistration is requested.

Further info: William M. Markel, MD, National Conference on Human Values & Cancer, American Cancer Society, Inc., 219 East 42nd Street, New York, NY 10017. □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Urge Early Submission of H of D Resolutions

The State Medical Society's House of Delegates will meet in annual session May 8, 9, and 10 at the Holiday Inn Central in Milwaukee.

County medical societies and scientific sections are urged to submit their resolutions early to facilitate better distribution of the printed materials to the delegates, allowing them an opportunity to more adequately represent their society or section.

The Society's Bylaws call for the filing of resolutions with the Secretary no later than 30 days prior to the first session of the House of Delegates which means the deadline for filing is April 10.

Any resolutions which call for conferences, studies, and the like which have a budgetary impact should be accompanied by a fiscal note. The Secretary's office is available for assistance in preparation of fiscal notes.

Plans for the annual scientific program of the State Medical Society are in the final stages as developed by the Commission on Scientific Medicine.

The major portion of the scientific program will be held Tuesday through Thursday, May 9–11, at the Sheraton–Schroeder Hotel. A few scientific lectures are scheduled at the Downtowner Motor Inn and Ramada Inn.

Last year's format of the scientific program will again be used including plenary sessions on Tuesday and Wednesday featuring "Current Status of Venereal Diseases" and "Infectious Disease Problems of Increasing Importance." On Thursday "Highlights of the Pharmacologic Essentials in Clinical Practice" and the Resident–Intern Papers program will be featured along with programs involving Anesthesia, Ophthalmology, Otolaryngology, Orthopedics, Physical Medicine and Rehabilitation, and Surgery. Specialties involved in the Tuesday and Wednesday programs include Allergy, Neurology, and Psychiatry on Tuesday and Dermatology, Plastic Surgery, and Public Health on Wednesday.

DOCTORS! IS YOUR HOBBY PHOTOGRAPHY?

If so, you'll want to enter **fotos/72,** the annual photography contest sponsored by the State Medical Society of Wisconsin. Entries are being taken now and winning photographs will be displayed at the Society's Annual Meeting in May in Milwaukee.

The contest is open to all State Medical Society members. **fotos/72** details and entry form appear on page 9 of this issue.

Auxiliary Art Show Has New Twist

A Traditional Crafts and Fine Arts Show will be held at the Annual Meeting, May 8, 9, 10. The show, sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin, will be held in the East Room of the Sheraton–Schroeder Hotel in Milwaukee.

Co-chairmen of the event are Dr. and Mrs. John Smith and Dr. and Mrs. John Chamberlain, all of Milwaukee.

Any member of the State Medical Society or a spouse may enter the show, which is expanded to include more categories this year. Articles may be entered in the following classes: Ceramics; Drawings and Graphic Arts; Paintings (acrylic, oil, watercolor); Photography; Sculpture; and Three Dimensional Design, including crewel, needlepoint, macrame, metalwork, lapidary, pottery, weaving and textiles, woodwork.

Ribbons will not be awarded (as in past years) as entries will not be judged by a professional this year. Viewers will vote for the "Best of Show" awards in each category.

If exhibitors wish to sell articles, they may attach a card indicating this along with their name, address and price, so that the prospective buyer may contact the exhibitor.

The exhibitor must assume full responsibility for articles submitted, but every precaution against damage or theft will be exercised.

Watch next month's GREEN SHEET for entry blanks and further information.

Menominee County to Get Health Corps Physician

Menominee County seems on the threshold of having its own physician. This month the National Health Service Corps announced that an MD, a nurse, a health educator and a dentist have been approved for the area.

This month a NHSC team, to include the physician proposed for the area, is scheduled to meet with the Northeast Wisconsin Health Planning Council (NEWHPC) and others. Discussions may include housing and other arrangements. If the MD is acceptable to those concerned, he could be working in Menominee County by next month.

The request for Corps personnel came from the NEWHPC, which includes Menominee County within its boundaries. In October the State Medical Society made a special appeal to the U.S. Public Health Service endorsing the request.

Don Parrot, NEWHPC Associate Planner, has said that when the new physician is settled, a program will be organized to coordinate the efforts of MDs interested in helping the Menominee doctor. Mr. Parrot noted that in the past numerous physicians have volunteered their time to provide some medical care to the area. He said he hopes that this interest will continue since such services are now needed more than ever.

The NHSC was set up a year ago to assign U.S. Public Health Service personnel to areas of the United States where health services are inadequate because of critical shortages of health personnel. NHSC physicians are assigned to an area for two years as an alternative to two years military duty.

Plans call for the new physician to be located in clinic facilities at the Neopit Community Center. NHSC regulations call for any fees resulting from care by Corps personnel to "be deposited in the U.S. Treasury." Under current interpretations, this means neither the physician nor the Corps can keep any of the money for local expenses.

Fees for services are to be established based on several factors, including ability to pay. The program will be open to everyone in the community. According to Corps representatives, those able to pay will pay and those not able to pay won't have to pay.

Corps personnel are paid by the federal government and the community is expected to furnish the facility, some equipment, and set the stage for the doctor to stay after his two-year assignment ends.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1972 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

SMS committees *in action*

FAMILY PRACTICE RESIDENCY. Commission on Hospital Relations and Medical Education (CHRME), January 20, endorsed a proposal to expand the University of Wisconsin Medical School's Family Practice Residency program to other locations in the state such as Green Bay, Wausau, and Eau Claire.

POSTGRADUATE TEACHING PROGRAMS. Commission on Hospital Relations and Medical Education, January 20, acknowledged the financial problems in conducting such programs for the continued education of physicians and allied health personnel. Commission noted that it is unfair to require hospital patients to bear the cost. Commission recommended that this problem be brought to the attention of the Health Planning and Policy Task Force and the Health and Social Services Committee of the Assembly.

HEALTH EXAMINATIONS FOR STUDENTS. Division on School Health, January 27, proposed that there be a standard health examination for all students that would be acceptable to all schools, camps, organizations, and agencies; also that a standard reporting form be developed.

PHYSICAL EDUCATION. Division on School Health, January 27, recommended that the State Medical Society sponsor a one-day conference for state physicians and school board members to discuss the future role of physical education programs in the schools.

ALLIED HEALTH PERSONNEL. Division on Maternal and Child Welfare, January 29, noting the emerging role of the nurse midwife, urged the establishment of an experience "ladder" to enable allied health personnel to advance their educational status without duplication of course work.

HEMOAGGLUTINATION TEST FOR RUBELLA. Division on Maternal and Child Welfare, January 29, endorsed a recommendation that HIA tests be performed at the time of the premarital examination of the female, or on new female obstetrical patients who have not been tested.

HEXACHLOROPHENE. Division on Maternal and Child Welfare, January 29, considered the controversy on use of solutions containing hexachlorophene for bathing newborn infants but took no position on the issue until more conclusive evidence is available.

State H&SS Board to Advise Federal Price Commission

Governor Patrick J. Lucey has designated the board of the Health and Social Services Department as the official state advisory body to the Federal Price Commission in Wisconsin. The board will assist the commission in administering prices charged by hospitals and nursing homes in Wisconsin under Phase II of President Nixon's economic stabilization program.

The Governor of each state was requested by Commission Chairman C. Jackson Grayson, Washington, D. C., to designate an advisory board to assist the Price Commission.

The board will make recommendations on all requests from health institutions in Wisconsin to increase prices by 6% or more. Requests of less than 6% will be handled directly by the commission and the Internal Revenue Service.

SMS committees *in action*

REGIONAL PERINATAL CENTERS. Division on Maternal and Child Welfare, January 29, acknowledged the difficulties of financing regional perinatal centers and noted the pending state legislation which would provide for $250,000 in general funding through a $10 assessment per obstetrical patient. State Medical Society's Council has gone on record in support of the concept of this legislation, but would like to consider alternate means of financing. (Bill 597, S.)

EMERGENCY HEALTH SERVICES. Commission on Hospital Relations and Medical Education, January 20, acknowledged the training programs for ambulance drivers being given throughout the state by volunteer physicians and encouraged support of pending state legislation to license ambulance attendants and ambulance service managers. (Bill 367, A.)

OCCUPATIONAL HEALTH AND SAFETY ACT. Committee on Occupational Health of the Commission on Health Information, February 9, noted that the AMA is publishing a guide which will include a summary of OSHA and its medical implications. (The guide appears in *JAMA,* February 14 issue.) Committee acknowledged that all employers will now need to have a physician available for advice and consultation to comply with OSHA. Committee agreed to ask State Medical Society's Council to recommend that each county society have available an occupational health committee composed of physicians interested in filling this need.

OCCUPATIONAL HEALTH GUIDE. Committee on Occupational Health, February 9, encouraged the use of the State Medical Society's *Occupational Health Guide* by in-plant medical and nursing personnel. The manual is available from the Society for $6 with ring binder and $5 without binder. It covers everything from "abdominal injuries" to "wounds," with every item suggesting steps to be taken.

FARM ACCIDENT SYMPOSIUM. Committee on Occupational Health, February 9, discussed a Society-sponsored one-day program to focus on farm accidents. To allow greater participation by physicians and other interested persons and groups, the program will be presented in three locations: March 13 in Green Bay, March 22 in Eau Claire, and March 23 in Madison. Physicians are urged to attend and bring interested guests. Details also appear in this issue on page 8.

AMA Posts Go to Seven State MDs

Seven members of the State Medical Society have been recently appointed to American Medical Association committees and councils by the AMA Board of Trustees.

Wisconsin physicians starting new one-year terms are:

Joseph D. Farrington, MD, Woodruff, reappointed alternate representative of the American College of Surgeons on the AMA's Commission on Emergency Medical Services;

Roman E. Galasinski, MD, Milwaukee, reappointed to the Council on National Security and to the Committee on Community Emergency Services;

Otto T. Mallery, MD, Wausau, appointed to the Committee on Medicolegal Problems;

Ewald Pawsat, MD, Fond du Lac, reappointed to the Council on Voluntary Health Agencies and its Committee on Continuing Professional Education Programs;

James C. H. Russell, MD, Fort Atkinson, reappointed to the Committee on Exercise and Physical Fitness;

John O. Simenstad, MD, Osceola, reappointed to the Committee on Medicine and Religion;

Richard D. Stewart, MD, Brookfield, appointed to the Committee on Occupational Toxicology of the Council on Occupational Health.

Dr. Nordby Now Member of Orthopaedic Board

The Chairman of the State Medical Society's Council, E. J. Nordby, MD, was named chairman-elect of the American Academy of Orthopaedic Surgeons at its January 28 meeting in Washington, D. C. As an officer this makes Dr. Nordby a Board member of the organization, which has over 5,000 members. He has been in the practice of orthopedic surgery in Madison since 1946.

Wisconsin Legislative Roundup

The following is a listing of the key bills and their status as of February 16, 1972. A number of these were among the bills published in the November 1971 GREEN SHEET and are reprinted here because of a change in status. (A denotes Assembly bill, S denotes Senate bill.) Further information on other bills and an updating of status will appear periodically in the GREEN SHEET, in legislative bulletins, and in special communication to officers of county societies.

Bill	*Subject*	*Current Status*
53, A.	CHIROPRACTIC—AUTO LIABILITY INSURANCE POLICIES. Requires all auto liability insurance policies to provide medical payments coverage, and by Senator Knutson amendment, chiropractic treatment coverage. SMS OPPOSED.	Chapter 132—Laws of 1971
86, A.	BLOOD TESTS—introduced by Representatives Brown, Mittness and McCormick. Exempts physician or person working under his direction from civil or criminal liability in connection with withdrawing blood under the implied consent statutes.	Indefinitely postponed
206, A.	GENERIC PRESCRIBING—introduced by over 40 Representatives. Would require physicians to prescribe by generic name and require labeling by generic name. SMS position is that before any legislative action is taken, there should be created a study committee to conduct an analysis of generic name prescribing to determine whether and to what extent therapeutic equivalency exists; cost savings to patients that might reasonably be anticipated; and cost of implementing such a program. Substitute amendment 3 to the bill, supported by SMS, calls for study of equivalency before other legislation is enacted.	Substitute Amendment 3 passed Assembly giving preliminary OK in Assembly
482, A.	FAMILY PLANNING. Would provide for removal of contraceptives from statutory list of indecent articles. SMS SUPPORTS other family planning legislation (see Senate Bills 2 and 130), but has not taken a formal position on 482, A.	On Assembly calendar
707, A.	PHYSICIAN'S ASSISTANT. Provides that the Medical Examining Board shall establish standards for certifying individuals who hold themselves out as physician's assistants. SMS INTRODUCED AND SUPPORTED THIS LEGISLATION.	Passed Assembly; public hearing held by Senate Health and Social Services Committee
1104, A.	CERTIFICATE OF NEED would require the Department of Health and Social Services to issue a certificate based on need when a new health care institution was being constructed or an existing one altered. The Society recognized that a bill to require health planning agency approval should be enacted for *licensed* institutions, but does not favor the inclusion of unlicensed private facilities and professional services in such a proposal.	Passed Assembly, but *includes* many physicians offices
1391, A.	EMPLOYMENT OF PHYSICIANS BY HOSPITALS—introduced by Representative Czerwinski (D–Milwaukee) at request of the Governor. Would allow hospitals to employ physicians. The House of Delegates of the State Medical Society has recognized that employment of physicians may be necessary in some situations, but feels that any legislation must include the following if the interests of the patient and the physician are to be safeguarded: 1. Require contracts of employment be approved and supervised by the hospital's medical staff and filed with the Medical Examining Board. 2. Prohibit the limitation of medical staff membership in a hospital only to physicians employed by the hospital. 3. Continue the prohibition against hospital interference with the manner in which medicine is practiced. 4. Provide that the physician retain full professional liability for the patient's welfare. 5. Grant physicians full rights as employes, including the right of collective bargaining with the employer.	Assembly Health and Social Services Committee recommends passage of Substitute Amendment No. 1 (Note: Further amendments must still be accepted to implement SMS position.)
202, S.	CHIROPRACTIC AND PRIVATE HEALTH INSURERS—introduced by Senate Committee on Health and Social Services. Would make it mandatory for private health insurance plans to provide coverage for chiropractic services. SMS OPPOSES.	Passed Senate, and Assembly Health and Social Services Committee recommends passage
597, S.	PERINATAL HEALTH CARE AUTHORITY. Would create an independent perinatal health care authority for purpose of improving quality of health care for expectant mothers and newborn infants primarily through hospital-based programs. Program would be paid for by a $10 fee from each obstetrical patient. Society SUPPORTS concept of this legislation, but is working on suggested alternate means of financing.	Passage recommended by Senate Committee on Health and Social Services; referred to Joint Committee on Finance
879, S.	TREATMENT OF VD. Bill would permit a physician to treat a minor for VD on consent of such minor, if in the judgment of the physician there is a significant health hazard to the minor or the public. SMS SUPPORTS.	Passed Senate and referred to Assembly Committee on Health and Social Services

PRESIDENT'S PAGE

New Treatment for an Old Cult

By the time this page is published all physicians may know that the Medical Society has been forced to change its approach to the chiropractic legislation. The Governor and State Legislators have been thoroughly informed about the "chiro cult" and the lack of scientific basis for their activities and the inferior educational standards of their schools. In spite of this the Senate has seen fit to pass a bill requiring payment to chiros under health insurance.

Medicine has now attempted to turn to the public to educate and inform them of the lack of educational standards and scientific basis for this cult. With full-page ads in many daily newspapers and half-pages in others, the Medical Society has sought to take the mask off current chiropractic legislation and reveal the true issue: that no amount of state examining or licensing, no amount of legislating status or payment rights will ever make up for unsound theory and inadequate education.

The Senate hurriedly pushed Bill 202, S. through the floor with little notice, almost no discussion, and a voice vote with few dissenters. The bill was rushed to the Assembly where the health committee immediately took it up in Executive Session and recommended passage without a single word of public hearing. It seems incredible to me that the State of Wisconsin can spend tax monies and citizens' time on a "Task Force" to improve delivery of health care and then pass legislation that can only lower the quality of care and give credibility to an unscientific cult. We require much higher standards of education for Doctors of Veterinary Medicine to treat our animals than we now do of chiros who treat humans.

It seems to me that medicine will need to take a different attitude toward much of the legislation that has a bearing on medical practice. We have been ignored and overridden on matters that do not directly affect us as doctors, but affect only the public and their care. We must now take a closer look at those matters that directly affect medicine and our personal practices. The time is rapidly approaching when medicine will need to take a stand and not compromise its position.

G. A. Behnke M.D.

G. A. Behnke, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Pejorative Prescriptions

WE AS PHYSICIANS will be required to swallow many bitter pills in the decades to come. The growing public and legislative attention to our prescribing habits will be among the more bitter ones. Three basic questions are being raised. Each will have to be met in some manner. How we react, and what happens then, will somehow depend upon how fully aware we become of the implications of the criticisms. As we have learned, mere defensiveness or haughty retreat into "scientific professionalism" will leave us standing in line, maybe at the end of the line, along with chiropractors, naturopaths, and other *publicly defined* experts.

The first notion that has come into the public consciousness is that not all prescriptions written by doctors make sense. People know that placebos are given easily or that antibiotics may cover a lack of real information about a disease process. We all know that not all our carefully written prescriptions are filled, but Nader-like investigations of medical practice could only survive if significant portions of the public express a lack of credibility in what we do. Actual data is hard come by, but some have estimated that half of prescriptions written are never filled. Some of this practice may be due to cost factors, but much of the rejection is due to disbelief. As Adelaide laments, in the musical *Guys & Dolls,* "The medicine never gets anywhere near where the trouble is." The complaint is not against the hard-working doctor, nor against the discoveries of life-saving drugs, but against the stereotyping of prescriptions and of the non-specific use of certain drugs.

The second line of attack is much more broad, and in some ways more subtle. The first complaint can be heard in social groups and in all strata of our society. This second issue is only beginning to be heard, but it is sounded at legislative levels, in Washington no less, and from the editorial pages of our newspapers. The issue is the growing awareness of the extent and seriousness of the soft and hard drug problem in our world today. None of us knows the full reasons behind drug abuse, nor the meaning of our public's sudden and intense concern. But voices are being raised that identify medical prescribing with a more pejorative usage of drugs.

Some few blame physicians, and some have tried to show that the drug companies, by their ads and their emphasis, are creating a drug-oriented society. More careful thinkers, hopefully our effective politicians, understand that the fuller nature of the problem must take into account both the patient who demands a prescription for his ills and the physician who complies, perhaps even when his judgment might suggest delay. Physicians cannot shift out of this growing threat by claiming, like the young girl, that "he made me do it." But we can become aware of the implications of our role in a drug-oriented world, and ask the hard scientific questions of how and why . . . even if others merely hue and cry.

The third issue which may beset the medical practitioner in the years ahead is the still more complex complaint that disease itself may be approached in more than the strictly conventional way, that is drug dosage. Doctors who have practiced for a number of years understand that symbioses form between patient and therapist. One aspect of this may be the easy giving of prescriptions . . . for sleeping, for staying awake, for calming down, or whatever. The notion that these prescriptions are pejorative rests on the idea that symptom control . . . alone. . . may actually prevent the person from getting well, or from mustering the strength to begin to heal himself. It is possible that someone could defend this kind of practice by saying, "so long as they feel better and do not complain, what is the difference?", but most thoughtful physicians would reject this approach. The difference is that some are beginning to ask for a definition of what we are doing with our medical prerogative.

Just last month a directive came from a third party payment plan in another state requiring that to be eligible for payment for treating an emergency, a physician must describe in detail the emergency and justify three specific points about the event. With this as a prototype, can we evolve a system of similarly explaining stimulants, sedatives, and the like?

In a previous editorial I mentioned the fragmentation of medical practice. Detailed reporting, of itself, cannot be criticized, for the public merely wants to know that it is getting its money's worth. But what happens if detailed explanation is demanded of the patient's needs and of his communications to his doctor? If we talk about it now, we will be better prepared to deal with demands of this nature, and not merely submit to radical polarizations, or extremes, in ourselves or in the demanding public.—RH

The Long Road

ALMOST every mail contains one or another "drug warning." Even the newspapers over the past few years carry public warnings about one or another chemical. It is small wonder the physician, and sometimes his informed patients, become unsure just which new (or old) treatments can be effectively used without fear of untoward side-effects. Now comes the warning from the FDA (*Drug Bulletin*, November 1971), to the effect that diethylstilbestrol given to pregnant women may dispose the female child, years later, to the development of adenocarcinoma of the vagina. This warning was even carried to physicians editorially in the *JAMA* Dec. 6, 1971 issue, under the provocative title "Maternal Diethylstilbestrol a Time Bomb for Child?". In this issue of the *Wisconsin Medical Journal*, your attention is directed to a timely report by Drs. William Fetherston, Alfred Meyers, and Mark E. Speckhard, all of St. Mary's Hospital in Milwaukee. This scientific study is addressed to what they call the "Stilbestrol–Adenosis–Adenocarcinoma of the Vagina Syndrome" and the report covers studies of two such clinical problems in young women, including treatment suggestions and a warning of the need to consider stilbestrol as a cause of the cancer. It's certainly a long road from the little red pill, which I first met clinically in uncomplicated and unfeared form, back in 1942 while still in medical school.

Every physician learns the dangers of interfering with the chemistry of the body, especially the endocrine balance. This is one more evidence of the effect of interfering with nature.—RH □

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Help for the Elderly—A Voluntary Service

From November 28 through December 2, 1971, I attended the White House Conference on Aging in Washington, D.C. as a presidential delegate from Wisconsin.

The magnitude of the problems of older Americans was spelled out dramatically during that week in Washington.

There were 3400 delegates registered and assigned to sections and subsections. These professional men and women and concerned citizens had a sense of urgency about their mission . . . to find a way for people in the over-65 age group to get a "break in life."

This was not a convention but rather a "task force" determined to listen, discuss, formulate ideas, and to recommend action to carry out those ideas.

By dividing the conference into subsections, everyone was heard. And there was an open forum for those who wanted to address the entire delegation. Democracy was surely at work for I sat next to a Navajo Indian lady, dressed in her native costume, who talked with me and to our group. Another day I shepherded a wonderful 95-year-old gentleman from Utah who gave me much inspiration with his thoughtful alertness, wisdom, and knowledgeable suggestions.

There were 13 sections involving specific areas of concern to the senior citizens. These were divided into 95 subsections. I was involved in the section on Physical and Mental Health and in the Special Concerns Sessions of Rural Older People and Volunteer Roles for Older People.

By special invitation of the AMA, I met with the physician delegates at their special orientation meetings during this conference. I was impressed with the physicians' dedication of purpose, their sense of urgency, and their preparation of constructive ideas.

Frederick Schwartz, MD of Lansing, Mich., chairman; Edward Lorenz, MD; Paul Rhoads, MD; and Pierre Salmon, MD are men with tremendous leadership qualities. They were the spark plugs of the AMA's Committee on Aging. Among the other physicians in attendance was Paul Dudley White, MD, who made an interesting comment that in China there are no homes for the aged . . . the families are back together and there is no dependence on psychiatry . . . they work physically hard and have no time for mental illness.

John A. Scharffenberg, MD was chairman of my subsection on Physical and Mental Health, a physician admirably informed, organized, and dedicated to the purpose of the conference.

From these men and others came recommendations to help solve the problems of day-to-day living . . . that there be encouragement to the elderly to continue to be useful, that there be no discrimination on age, that there be no retirement on the basis of chronological age, that there be continued effort to educate the older Americans so that they can feel useful, and that society educate itself in the problems of aging.

Out of this conference came my impressions of priority of need, and it was *not* necessarily that health care should come first. The greatest concern was the *lack of financial security*. The older people don't have enough money to live as a result of our economy. Health care was a consideration but it was the *delivery* and not the quality.

The monstrous task of determining how much it costs to live in all sections of this country can never be finished, but it was a feeling of the delegates that the government cannot be allowed to do everything for the older persons but that each person, young and old, can help through voluntary services.

With the older Americans, it is the little things of life that make it worthwhile living and this idea leads directly to the services of the volunteer.

Transportation, the need and lack of, is high on the list of needs. Services are available if people can get to them . . . the hospital, the doctor, the grocery store, the library, the church, to visit friends. . . .

Lack of social contact is another problem. A regular personal visit to the elderly who feel no longer needed or wanted can pave the way for many projects in every community. The role of the volunteer is a critical factor but one in which the physician's wife . . . our auxiliary . . . can be a leader. We can help with the older volunteer whose worth and talents are a great national resource. These people need our support in their training, their growth, and in recognizing their accomplishments.

We can educate ourselves to recognize that it is the little things of life which compound; and if we can keep these little problems small, the big problems will not seem so disastrous. Our help in alleviating the loneliness, the sense of being unwanted, the lack of something to do, recognizing their need for identity, meaning, love, wisdom should be one of our goals.

Out of the sections on Health, a preamble was authored by us asserting that the United States of America must guarantee to all its older people health care as a basic right and a quality of life consistent with that which our nation should assure to this group who has made invaluable contributions to its development. In order to assure that quality of life, a basic requirement is the availability of a comprehensive system of appropriate health care. In order to achieve this, a comprehensive and systematic health care must provide: assessment of health, education to preserve health, appropriate preventative and out-reach services, all physical-mental-social-supportive services necessary to maintain or restore health, rehabilitation, and maintenance and long-term care when disability occurs.

The problems of the elderly are almost overwhelming but the delegates recognized this and instead of sweeping them under the rug, the White House Conference on Aging met them head-on and each delegate signed a pledge to spend a specific amount of time this coming year to help alleviate the desperate needs of the older Americans.

I made my pledge and with the help of the physicians and their wives, we can help Wisconsin to be a great state in which to grow old. Our progressive ideas on volunteer services can be a great place to start. This can include the volunteer services of the young, the middle-aged, and best of all the older Americans who can be the best volunteers of them all. If we can make our older friends happier, they will all feel better.

MRS. D. G. (MARIAN) MACMILLAN
President, Woman's Auxiliary
to State Medical Society of Wisconsin

□

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

SECTION

OPHTHALMOLOGY

FEBRUARY 1972

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

LEARNING DISABILITIES

The Section on Ophthalmology of the State Medical Society of Wisconsin was represented at the recent conference on learning disorders at Atlantic City, New Jersey, by two ophthalmologists and their two guests.

Elmer Johnson, MD of Madison had as his guest, Mr. Thomas Scharf. Mr. Scharf is director of special education for the Wisconsin Department of Public Instruction.

Walter Gager, MD of Waukesha had as his guest, Mr. Mel Yanow. Mr. Yanow is from the special education department of the Milwaukee school system.

The conference included educators, ophthalmologists, pediatricians, neurologists, psychologists, and psychiatrists. The conference was well attended by physicians and educators.

The conclusions of the conference were as follows:

THE EYE AND LEARNING DISABILITIES

The problem of learning disability has become a matter of increasing public concern, which has led to exploitation by some practitioners of the normal concern of parents for the welfare of their children. A child's inability to read with understanding as a result of defects in processing visual symbols, a condition which has been called dyslexia, is a major obstacle to school learning and has far reaching social and economic implications. The significance and magnitude of the problem have generated a proliferation of diagnostic and remedial procedures, many of which imply a relationship between visual function and learning.

The eye and visual training in the treatment of dyslexia and associated learning disabilities has recently been reviewed with the following conclusions by the American Academy of Pediatrics, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology:

1. Learning disability and dyslexia, as well as other forms of school underachievement, require a multi-disciplinary approach from medicine, education, and psychology in diagnosis and treatment. *Eye care should never be instituted in isolation when a patient has a reading problem.* Children with learning disabilities have the same incidence of ocular abnormalities, e.g., refractive errors and muscle imbalance, as children who are normal achievers and reading at grade level. These abnormalities should be corrected.

2. Since clues in word recognition are transmitted through the eyes to the brain, it has become common practice to attribute reading difficulties to subtle ocular abnormalities presumed to cause faulty visual perception. Studies have shown that *there is no peripheral eye defect which produces dyslexia and associated learning disabilities.* Eye defects do not cause reversals of letters, words, or numbers.

3. No known scientific evidence supports claims for improving the academic abilities of learning-disabled or dyslexic children with treatment based solely on:

(a) visual training (muscle exercises, ocular pursuit, glasses),

(b) neurologic organizational training (laterality training, balance board, perceptual training).

Furthermore, such training has frequently resulted in unwarranted expense and has delayed proper instruction for the child.

4. Excluding correctable ocular defects, glasses have no value in the specific treatment of dyslexia or other learning problems. In fact, unnecessarily prescribed glasses may create a false sense of security that may delay needed treatment.

5. The teaching of learning-disabled and dyslexic children is a problem of educational science. No one approach is applicable to all children. A change in any variable may result in increased motivation of the child and reduced frustration. Parents should be made aware that mental level and psychological implications are contributing factors to a child's success or failure. Ophthalmologists and other medical specialists should offer their knowledge. This may consist of the identification of specific defects, or simply early recognition. The precursors of learning disabilities can often be detected by three years of age. Since remediation may be more effective during the early years, it is important for the physician to recognize the child with this problem and refer him to the appropriate service, if available, before he is of school age. Medical specialists may assist in bringing the child's potential to the best level, but the actual remedial educational procedures remain the responsibility of educators.

During the month of December 1971, this information was sent to all major newspapers in the state. Their cooperation in publicizing this information was most gratifying.

NEW EYE BANK CHIEF IN MILWAUKEE

Robert A. Hyndiuk, MD is now chairman of the Eye Bank Committee of the Wisconsin Lions Eye Bank in Milwaukee. Doctor Hyndiuk spent several years of post residency fellowship training at Boston and Florida studying the diseases and surgery of the cornea. He is a member of the Department of Ophthalmology at the Medical College of Wisconsin in Milwaukee.

DATES TO REMEMBER

Mar. 28: Milwaukee Ophthalmological Society. Dr. B. Thomas Hutchinson is the speaker.

April 23: Milwaukee Ophthalmological Society. Dr. James D. Kingham of the Medical College of Wisconsin will be the speaker. □

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NEWS HIGHLIGHTS

• MILWAUKEE ACADEMY OF MEDICINE . . . at its 86th annual meeting January 18 installed the following officers for 1972: president—Wayne J. Boulanger, MD;* president-elect—Donald P. Babbitt, MD*; vice-president—Harold F. Hardman, MD;* secretary—Donald A. Roth, MD;* treasurer—David V. Foley, MD;* and librarian—Sanford R. Mallin, MD.*

• WISCONSIN PSYCHIATRIC ASSOCIATION . . . will hold its annual meeting February 25–26 at the Park Motor Inn in Madison. The preliminary program includes the following topics and speakers: *Psychiatry and Women,* Richard J. Thurrell, MD;* *National Health Insurance Plans and Mental Health Coverage,* Leigh M. Roberts, MD;* *Correctional Psychiatry,* Dr. Thurrell; *Relevance of Recent Advances in the Psychobiology of Affective Disorders to Clinical Practice,* Peter Whybrow, MD, chairman of the Department of Psychiatry, Dartmouth Medical School; *Personality as Reflected in Responses to Terminal Illness,* Leon Epstein, MD, vice-chairman, Department of Psychiatry, University of California at San Francisco. William McKinney, MD is program chairman.

• AMERICAN COLLEGE OF PHYSICIANS . . . has admitted as members the following Wisconsin MDs: Martin Janis,* Madison; William J. Maurer,* Marshfield; David G. Kamper* and Lawrence V. Perlman, Milwaukee; and John A. Frantz,* Mary H. Frantz,* and Bill L. Maddix,* Monroe.

• MEDICAL COLLEGE OF WISCONSIN . . . has been awarded two cancer research grants totaling $10,800 by Milwaukee Division of American Cancer Society. Grants were given to Richard I. H. Wang, MD, PhD,* professor of clinical pharmacology, who received $3,000, and Harold M. Swartz, MD, PhD, associate professor of radiology, radiation therapy department, received $7,800. Funds were obtained through annual Cancer Crusade.

• ST. JOSEPH'S HOSPITAL, MILWAUKEE . . . in mid-January honored 50 physicians who have been active on its medical staff for 25 years or longer. Following a special dinner each physician was presented an individual plaque commemorating the number of years served. The accumulated number of years served by the 50 physicians total 1,775 years.

• DE PAUL REHABILITATION HOSPITAL, INC. . . . a 102-bed, non-profit institution in Milwaukee for the treatment of alcoholism and drug-related illnesses, has been accepted for affiliate membership in the Medical Center of Southeastern Wisconsin, a voluntary federation of a number of hospitals and other health care institutions designed to coordinate and improve health care, research, and education in the area.

PHYSICIAN BRIEFS

Leonard J. Ganser, MD*

. . . Madison, has been appointed to the National Advisory Council on Services and Facilities for the Developmentally Disabled. The Council serves as an advisor to the U.S. Secretary of Health, Education, and Welfare on regulations and federally funded programs for persons with developmental disabilities. In addition, the Council generates ways to help states plan and develop services for this group. It also acts as national spokesman for all disabled persons. Dr. Ganser is administrator of the State Department of Health and Social Services' Division of Mental Hygiene. He will serve on the 17-member Council until Aug. 31, 1974.

James L. Weygandt, MD*

. . . Sheboygan Falls, was elected president-elect of the American Association for Automotive Medicine during its meeting recently in Colorado. He had served as its secretary. He will assume the presidency next October.

Thomas E. Dugan, MD*

. . . New Berlin, recently was reelected chief of staff of Waukesha Memorial Hospital.

Roger C. Cantwell, MD*

. . . Shawano, one of the founders of the Cantwell–Peterson Clinic, recently was honored for 50 years of medical practice in the Shawano area. Active in community affairs, Doctor Cantwell was recipient of the Shawano area Chamber of Commerce Distinguished Citizen Award and also was elected to the American College of Physicians and Surgeons in 1968.

Ihor A. Galarnyk, MD*

. . . Plain, recently was named a charter diplomate of the American Board of Family Practice.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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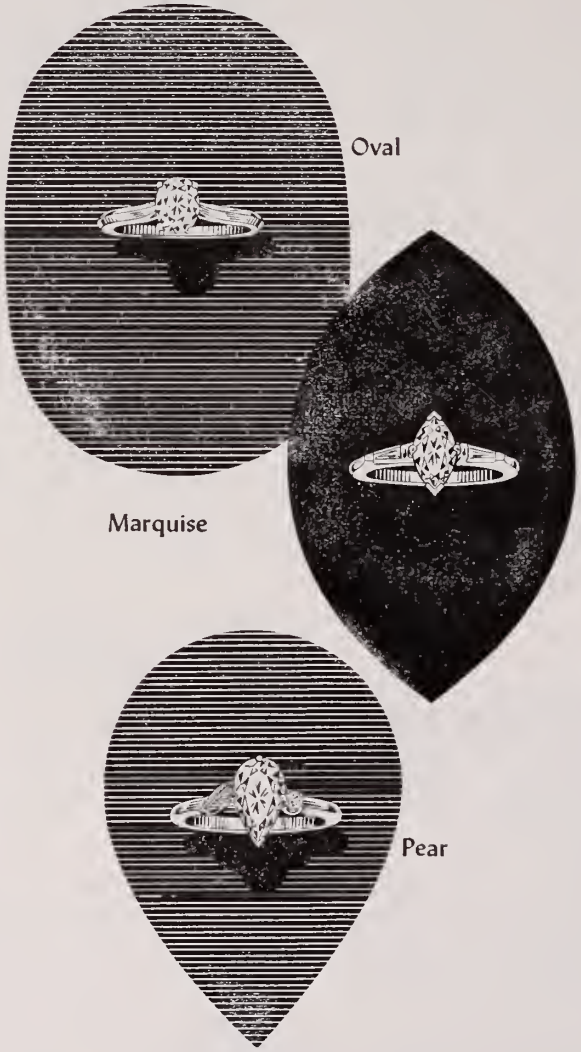

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1972 Annual Meeting

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Milwaukee

May 7–8–9–10–11

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1971

4	Madison General Hospital Surgical Staff
4	Madison Urological Society
4	Madison Anesthesiology Society
4	Dane County Medical Society Board of Trustees
6	Madison and Area Otolaryngologists Seminar
6	Peer Review Study Committee
10	Dane County Medical Society Insurance Advisory Committee
11	State Medical Examining Board
12	State Medical Examining Board
12	Convention Planning Committee, Woman's Auxiliary to SMS
13	State Medical Examining Board
13	Madison Academy of Internal Medicine
14	Wisconsin Nutrition Council
17	Peer Review Study Committee
20	Executive Committee, CES Foundation
20	SMS Commission on Hospital Relations and Medical Education
21	Peer Review Study Committee
22	Executive Committee of SMS Council, Executive Committee of SMS Commission on Medical Care Plans
24	State Pharmacy Board Exams
25	Dane County Medical Society Utilization Review Plan
27	SMS Division on School Health
27	SMS Division on Handicapped Children
28	Task Force Steering Committee
28	Peer Review Study Committee
29	SMS Division on Maternal and Child Welfare

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

• ST. FRANCIS HOSPITAL, MILWAUKEE . . . established a Milwaukee-based board of trustees when new bylaws were signed January 12. Sister M. Paschalisa, administrator, said the new board assumes legal and moral responsibility for the operation and the policy formation of the hospital. Ownership, however, has been retained by the Felician Sisters of Chicago, Illinois, who constructed the hospital during 1956. The new board of trustees, which will administer the assets of the 10-million-dollar, non-profit corporation, includes business, industrial and business executives, physicians, religious, consumers, and homemakers. Roman E. Galasinski, MD* served as acting chairman of the board at the special press conference called for the signing of the bylaws.

• NATIONAL ASSOCIATION FOR SICKLE CELL DISEASE . . . a national non-profit organization to combat sickle cell disease was formed December 11–12, 1971, in Racine by delegates of 18 sickle cell organizations throughout the states. The new association intends to concentrate its efforts on building a national program of education, detection of carriers, services, genetic counseling, and research on the disease and its multiple effects on blacks. George Lane, MD,* director of the sickle cell anemia center at Deaconess Hospital in Milwaukee, was one of the delegates.

• MEDICAL COLLEGE OF WISCONSIN . . . faculty members in neurology are testing a new drug which may improve the control of petit mal epilepsy. The drug study is under the direction of Paul R. Dyken, MD,* associate professor and chairman of the Neurology Department and also director of pediatric neurology at the college and at Milwaukee Children's Hospital. Drug being tested is a benzodiazepine called Clanazepam. It is part of the family of chlordiazepoxide (Librium) analogs. Efficacy of benzodiazepine will be compared with that of ethosuximide, one of the newer drugs used to treat absence seizures, and the most effective one to date, according to Dr. Dyken. He says that it is possible the new drug, alone or in combination with ethosuximide, may raise the 50 to 60 percent total control achieved with just ethosuximide. Study is limited to 50 patients, referred from private physicians or clinics. Twelve already have undergone initial testing and begun a medication program, but new patients are still being selected. Drug comparison results from the Medical College of Wisconsin will be combined with findings from similar tests at the University of Virginia Medical School in Charlottesville. Both sites are operating under grants from the National Institute of Neurological Diseases and Stroke. Grant for the Milwaukee testing is $114,363 over four years. Dr. Dyken is being assisted by Stanley Johnsen, MD, assistant professor of Neurology and Neurology in Pediatrics at MCW, and by Philip T. White, MD,* associate dean of MCW.

• LATE SARAH ROSEKRANS, MD. . . . has been memorialized with the recent establishment of the "Dr. Sarah Memorial Medical Library" at the Neillsville Memorial Hospital. Dr. Rosekrans died November 15, 1970, after having served the community for 40 years.

Sr. Paschalisa Dr. Galasinski

Walter P. Blount, MD*

. . . emeritus professor of orthopaedic surgery, Medical College of Wisconsin, Milwaukee, heads a faculty of 32 scheduled speakers for the postgraduate course on Fractures and Other Trauma to be presented May 10–13 at the Sheraton–Chicago Hotel in Chicago. The course is sponsored by the Chicago Committee on Trauma of the American College of Physicians. Doctor Blount is a past president of the American Academy of Orthopaedic Surgeons and author of "Fractures in Children," of which a new edition is about to be released.

Armand J. Quick, MD*

. . . Milwaukee, professor emeritus of biochemistry at the Medical College of Wisconsin, recently was elected a foreign correspondent of the French National Academy of Medicine. He joins nine other Americans who have been so honored by the French.

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Glen P. Hung, MD

. . . Watertown, recently opened offices as the first full-time specialist in obstetrics–gynecology in Watertown. Doctor Hung, a graduate from the National Taiwan University School of Medicine, was engaged in private practice in Taiwan for several years. He returned to this country in 1969, and served for a year as House Physician at Hartford Memorial Hospital in Harve de Grace, Md. Prior to opening his practice in Watertown, he was on the medical staff of Wood VA Hospital, Milwaukee.

Herman R. Thomas, Jr., MD

. . . Fond du Lac, recently was named chief of the medical staff at St. Agnes Hospital, Fond du Lac. Doctor Thomas succeeds Norman Becker, MD,* who served for two years.

George L. Lucas, MD*

. . . Madison, recently was elected to membership in the Association of Bone and Joint Surgeons and the American Association for Hand Surgery.
Physicians Briefs—10 on 10 TR

Joseph E. Powell, MD

. . . New Richmond, recently became associated with the New Richmond Clinic, S.C. Doctor Powell is a graduate of Indiana University School of Medicine and served his internship at Denver, Colo. Prior to joining the New Richmond Clinic, he had practiced in Peoria, Ill.

Robert T. Willis, MD

. . . Sheboygan, has become associated with the staff of the Sheboygan Clinic. Doctor Willis, a graduate of Baylor College of Medicine, Houston, Tex., served his internship at Baylor Affiliated Hospitals, Baylor College of Medicine. He was a flight surgeon with the United States Air Force for two years, and since 1967 has been in resident training at the Mayo Clinic, Rochester, Minn., in the Department of Internal Medicine.

J. W. Weber, MD*

. . . New London, recently was elected president of the medical and dental staff of the New London Community Hospital. He succeeds Luis L. Galang, MD.*

CONTRIBUTIONS—CES FOUNDATION

December 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for December 1971:

Nonrestricted

State Medical Society Members	Voluntary contributions of 10 MDs
Robert B. Murphy, Anne E. Roethke, MD, Garrett A. Cooper, MD, Jack Teasley, MD, & June Miller, TPN	Contributions
Ervin L. Bernhart, MD, Dr. & Mrs. Karl Ruppenthal	Memorial: James C. Fox, MD
W. T. Russell, MD	Memorial: Charles Stoops, MD
Charles J. Picard, MD	Memorial: James W. McGill, MD
Mr. & Mrs. Howard Brower	Memorial: J. D. McCarrtry, MD
Dr. & Mrs. W. D. James	Memorial: Robert I. Sorenson, MD
Mr. & Mrs. Earl R. Thayer, Dr. & Mrs. George A. Behnke, Leslie E. Jones, MD, Robert W. Baird & Co., Inc., Mr. & Mrs. Louis Peterson	Memorial: Gordon Schulz, MD
E. J. Nordby, MD	Memorial: Frank E. Cairns
Mrs. Robert W. Burns	Memorial: Emma VanderZanden
The David Beale Family, Margaret K. Pharo	Memorial: Charles Sablotni

Student Loans

State Medical Society Members	Voluntary contributions of 5 MDs

Scientific Teaching—General

State Medical Society Members	Voluntary contribution of 1 MD

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 4 MDs
William H. Frackelton, MD	Contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Robert I. Sorenson, MD

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Tormey Memorial Fund

Mr. & Mrs. Joseph G. Werner	Memorial: Mrs. Doris Yeager
Thos. W. Tormey, Jr., MD	Contribution

Dr. Grinde—Bell Account

Mr. & Mrs. Rolf Ethum, Mr. & Mrs. Urban Bollig	Contributions
Anonymous	Memorial: Mr. David Kirley
John M. Grinde, MD	Memorial: W. D. Stovall, MD

Cyrus G. Reznichek, MD—Student Loan Fund

W. T. Russell, MD, Mr. & Mrs. Henry Buslee, Mr. & Mrs. Orv Okre, Mr. & Mrs. P. J. Stahl, Mrs. Esther McDonald, RN, Mr. Dick Togstad, Mrs. Lynn J. Togstad, & Reliable Life & Casualty Co.	Memorial: Cyrus G. Reznichek, MD

W. D. Stovall, MD Memorial Account

Leland Pomainville, MD, Stanley Inhorn, MD, Carson & Frances Easton, Washington County Medical Society, Dr. & Mrs. Fred J. Hodges, William B. Hildebrand, MD, R. G. Edwards, MD, Mr. & Mrs. J. D. Stovall, Gunnar Gundersen, MD, Medical Faculty University of Wisconsin Center for Health Sciences, Mr. & Mrs. R. J. Anderson, Mr. & Mrs. M. Starr Nichols, George & Heidi Angell, Mr. & Mrs. J. O. Hirschfelder, Ralph C. Frank, MD, Rea & Roy Ragatz, Sverre Quisling, MD, M. O. Boudry, MD, Dr. & Mrs. Robert M. Senty, Dr. & Mrs. W. B. Youmans, Mrs. James C. Fox, Ovid O. Meyer, MD, Ruby Bere, Nelson Muffler Corp., Wisconsin Public Health Assoc., Inc., Dr. & Mrs. P. B. Blanchard, M. F. Huth, MD, The Sheboygan Clinic Foundation, Ervin L. Bernhart, MD, W. T. Russell, MD, O. H. Hanson, MD, J. J. Harris, MD,

• MARSHFIELD CLINIC FOUNDATION FOR MEDICAL RESEARCH AND EDUCATION . . . has been awarded a three-year renewal federal grant totaling $81,504 for continued study of farmer's lung. Grant comes from Department of Health, Education, and Welfare's National Institute for Occupational Safety and Health. Dean A. Emanuel, MD* of Marshfield Clinic is head of research project.

• RACINE MEDICAL CLINIC . . . has begun construction on a two-level addition that will nearly triple the size. Scheduled for completion in mid-August, the expansion will bring the clinic's square footage to 40,000 from the present 15,000. George Gillett, MD,* president of the service corporation that operates the facility, said the addition will house the clinic's department of internal medicine, clinical laboratory, multiphasic health examination area, cardiac testing and stress monitoring area, gastroenterology laboratory, as well as records area, clinic administrative offices, and unfinished space that could serve up to eight more physicians in the future.

CES FOUNDATION CONTRIBUTIONS *continued*

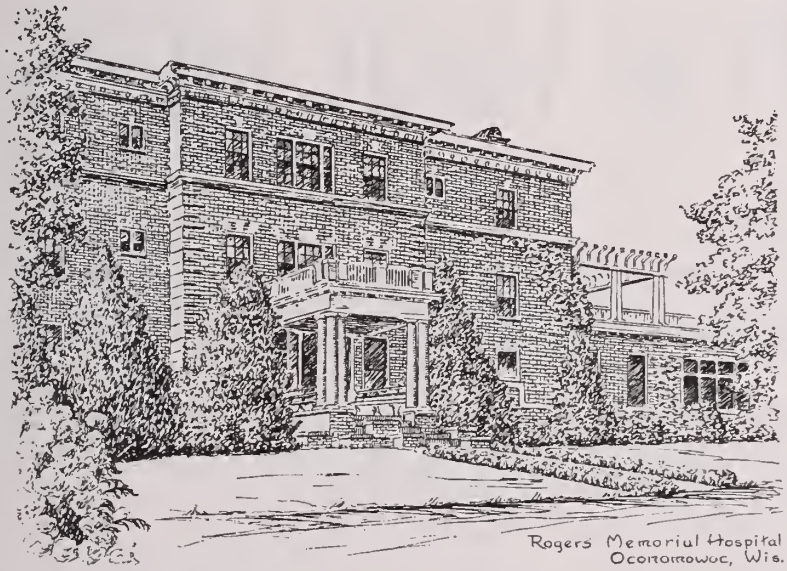
Laura M. Braunel, Employees of State Laboratory of Hygiene and Wisconsin Division of Health and Section on Patient Care Practices Staff Members, Charles J. Picard, MD, Dane County Medical Society, Robert B. Murphy, J. Mitchell Mackey, Frank R. Harner, Alfred S. Evans, MD, Dr. & Mrs. W. D. James, Mrs. H. C. Faville, Miss Margaret Taylor, Mr. & Mrs. Russell Clemons, Mr. & Mrs. Gilbert Esser & Family, Walter Rhodes, Mr. & Mrs. Claude S. Hayes, Marilyn Hennessy, Betty W. Westphall, Dr. & Mrs. Robert E. O'Connor, & Dr. & Mrs. George A. Behnke ---------- Memorial: W. D. Stovall, MD

Ovid O. Meyer, MD*

. . . Madison, consultant in research and education at the Veterans Administration Hospital, recently was featured in "Know Your Madisonian" in the *Wisconsin State Journal.* Twice in the last seven years, Doctor Meyer has retired. First in 1964, as chairman of the department of medicine at the University of Wisconsin Medical School and in 1971, as a professor on the medical school staff, after 40 years of treating patients at University Hospitals and teaching at the medical school. Still active, he makes his rounds, teaches and shows little evidence of slowing down, the article reported.

Robert H. Dorr, MD*

. . . Belgium, recently was the guest of honor at a testimonial dinner for his 25 years of practicing in the Belgium area. Doctor Dorr, past president of the Ozaukee County Medical Society and a member of the medical staff at St. Alphonsus Hospital, Port Washington, started practicing at Belgium in 1946.



MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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David J. Ottensmeyer, MD*

. . . was recently elected to serve as president of the Marshfield Clinic by that organization's board of directors. He succeeds Ben R. Lawton, MD.* A native of Superior, Doctor Ottensmeyer joined the Marshfield Clinic staff in 1965 as a Board-certified neurological surgeon. He will head the clinic of 105 medical specialists for one year. Doctor Ottensmeyer is a 1959 graduate of the University of Wisconsin Medical School in Madison. He also interned and completed his residency at University Hospitals there. In addition to his practice at the Marshfield Clinic, Doctor Ottensmeyer is presently serving as a clinical instructor in surgery at the University of Wisconsin in Madison.

Ana Capati, MD*

. . . Neillsville, recently was named chief of staff of Neillsville Memorial Hospital. She succeeds Cahit Ozturk, MD.* Doctor Capati has been practicing in Neillsville since 1967. □

County Medical Society *happenings*

• BROWN—*Dec. 9, 1971:* Reported membership at 152. Announced that any physician who has been in practice over 50 years or who is over 70 years of age become honorary members. Stewart L. Griggs, MD* of Green Bay passed the gavel to Henry C. Rahr, MD* of Luxemburg who took over as the president for 1972. Society meetings for 1971 were taped and are available to members upon request to the secretary, Donald R. Sipes, MD,* Green Bay.

• WOOD—*Dec. 20, 1971:* Elected the following officers for 1972: president, Robert L. Johnson, MD,* Wisconsin Rapids; vice-president, R. L. Hansen, MD,* Marshfield; and secretary–treasurer, Francis Kruse, Jr. MD,* Marshfield. J. J. Mulvaney, MD* of Marshfield discussed "The Drug Problem in Wood County" and J. W. Schaller, MD* of Wisconsin Rapids followed with comments.

• WALWORTH—*Jan. 20, 1972:* Elected new officers as follows: president—Irwin J. Bruhn, MD,* Walworth; vice-president—Glenn A. Smiley, MD,* Delavan; and secretary–treasurer—Roger D. Petersen, MD,* Elkhorn. The State Medical Society's field representative, W. J. (Jack) Brown, addressed the eleven members present on legislative matters and Medicare. □

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Ralph Chicorel

Ralph Chicorel, President

OBITUARIES

Kenneth G. Wertz, MD, 61, Brookfield, died Sept. 15, 1971, in Milwaukee.

Born on Dec. 18, 1909, in Harrisburg, Pa., Doctor Werts graduated from Hahnemann Medical College, Philadelphia, Pa., in 1942 and served his internship at Hahneman Hospital and residency at Mansfield General Hospital, Mansfield, Ohio.

He was a member of Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Carl Oliver Diamond, MD, 67, Fox Point, died Sept. 17, 1971, in Milwaukee.

Born on Dec. 1, 1903, in Woodbine, New Jersey, he graduated from Ohio Western Reserve University Medical School in 1928 and served his internship at Cleveland City Hospital, Ohio. His residency was taken at the Veterans Administration Hospital, Milwaukee, where he was acting chief of surgery from 1929 to 1933. He then opened a private practice in Milwaukee. He was on the medical staff of Mount Sinai Medical Center.

Doctor Diamond was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ruth; a daughter, Mrs. Richard (Joan) Strauss, Bayside; and a son, Dr. Darryl M. of Los Angeles, Calif.

Theodore J. Kroyer, MD, 67, Walworth, died Sept. 28, 1971, in Walworth.

Born on Oct. 10, 1903, in Oshkosh, he graduated from the University of Wisconsin Medical School in 1934 and served his internship at St. Mary's Hospital, Madison. He served in the United States Navy during World War II as a medical officer.

Doctor Kroyer was a member of the Walworth County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are three sons, Lt. Cmdr. G. Peter Kroyer, LeMoore, Calif.; Capt. James Kroyer, Nellis, Nev.; and John Kroyer, Hollywood, Fla.

Benjamin Albert Ruskin, MD, 66, Milwaukee, died Sept. 28, 1971, in Milwaukee.

Born on Aug. 10, 1905, in Toronto, Canada, Doctor Ruskin graduated from the University of Toronto Medical School in 1929. He was on the staff of Milwaukee Psychiatric Hospital for many years and went into private practice of psychiatry in 1959. Doctor Ruskin served in World War II in the United States Army Medical Corps.

He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, Milwaukee Academy of Medicine, and was a past president of the Milwaukee Neuropsychiatric Society and a fellow of the American Psychiatric Association.

Surviving is his widow.

John William Lowe, MD, 74, former Eau Claire physician, died Oct. 4, 1971, in Phoenix, Ariz.

Born on Apr. 19, 1897, in Whitehall, Doctor Lowe graduated from the University of Chicago Medical School in 1924, and served his internship at Grant Hospital, Chicago, Ill.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, State Medical Society of Wisconsin, and the American Medical Association.

Surviving is his widow.

Edward Thomas Sheehan, MD, 61, Wauwatosa, died Oct. 11, 1971, in Milwaukee.

Born on Dec. 2, 1970, in Pittsfield, Mass., he graduated from the University of Wisconsin Medical School in 1944 and served his internship at Columbia Hospital, Milwaukee. His residency was taken at the Veterans Administration, Mendota State and Tomah hospitals. At the time of his death, Doctor Sheehan was a clinical professor of psychiatry at the Medical College of Wisconsin and was a consultant at the Wood Veterans Administration Hospital. He was a fellow of the American Psychiatric Association and also served in the United States Army during World War II.

He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are four sons, James, Michael, Christopher, Patrick; and three daughters, Colleen, Ellen and Kathleen.

Mynie Gustave Peterman, MD, 75, pediatrics specialist in Milwaukee for over 40 years, died Oct. 14, 1971, in Milwaukee.

Born on Mar. 5, 1896, in Merrill, Wis., Doctor Peterman obtained a Bachelor of Science degree from the University of Wisconsin in 1918 and in 1920 graduated from Washington University Medical School, St. Louis, Mo. He served an internship in Barnes Hospital, St. Louis and in 1921 and 1922 was chief resident in surgery in Ancker Hospital, St. Paul, Minn. In Oct. 1922, he went to the Mayo Graduate School of Medicine as a fellow in pediatrics and was appointed a first assistant in pediatrics at the Clinic in 1923. Doctor Peterman became a member of the Department of Pediatrics in 1924 and in 1925 moved to Milwaukee where he started a practice of pediatrics.

From 1925 to 1933, he was director of research and laboratories of the Milwaukee Children's Hospital and also the medical director of the St. Vincent's Infant Asylum. In 1928, he was appointed chairman of the pediatrics department of Marquette University Medical School (now The Medical College of Wisconsin). He also had been chief of staff of Milwaukee County General Hospital and was a member of the staff of Columbia Hospital.

From 1954 to 1964, he was a consultant in pediatrics to the United States Public Health Service and from 1964 to 1967 he was a senior consultant in the Bureau of Medicine of the United States Department of Health, Education, and Welfare in Washington, D.C. He also was a member of the staff of the Johns Hopkins Hospital, Baltimore, Md. In 1968 he returned to Milwaukee to resume a consultation practice in pediatric neurology.

In 1956 and 1957, he was chairman of the Section on Pediatrics of the American Medical Association and in 1960 was awarded the honorary degree of doctor of medicine by the University of Madrid.

Doctor Peterman was a "50 Year Club Member" of the State Medical Society of Wisconsin, a member of The Medical Society of Milwaukee County, American Medical Association, American Academy of Pediatrics, American Association for Research in Nervous and Mental Diseases, Central Society for Clinical Investigation, American Association for the Advancement of Science, American Epilepsy Society, International Pediatric Society, American Academy of Neurology, Milwaukee Pediatric Society, Osler Medical History Society, and an honorary member of the Madrid Pediatric Society.

Surviving are his widow, Mildred; a son, Dr. A. F. Peterman, Reno, Nev.; and a daughter, Mrs. Mary Jean Harris, Brown Deer.

George H. Smullen, MD, 60, Racine, died Oct. 19, 1971, in Chicago.

Born on July 4, 1911, in Johnstown, N.Y., Doctor Smullen graduated from Loyola Medical School in 1938 and served his internship at Hurley Hospital, Flint, Mich. His residencies were two years at Charity Hospital, New Orleans, La., and one year at King's County Hospital,

N.Y. From 1942–1948, he served with the United States Public Health Service and was assigned to military duty during World War II. Doctor Smullen had practiced in Racine since 1948 and was on the medical staff of St. Mary's and St. Luke's hospitals.

He was a member of the Racine County Medical Society, State Medical Society of Wisconsin, American Medical Association, Wisconsin Dermatological Society, and the American Academy of Dermatology.

Surviving are his widow, Marie; two sons, Dr. Michael J. Smullen and George Smullen, Jr., Milwaukee; and one daughter, Mrs. Mary Lee Croatt, New Berlin, Wis.

Ernest E. M. Mathias, MD, 85, retired pathologist, died Oct. 27, 1971 in Madison.

Born in Koenigsberg, Germany, he was a professor of pathology at the University of Breslau until 1938 when he came to the United States. He served as a research fellow at Yale University and later became head pathologist for the Mt. Morris, N.Y., Tuberculosis Hospital.

He was a member of the American Pathological Association and a fellow of the Royal Society of Health in England.

Surviving are a son, Rudolf Mathias, and a daughter, Mrs. Beate Brann, both of Madison.

Ralph T. Sproule, MD, 46, Milwaukee, died Oct. 30, 1971, in Milwaukee.

Born Aug. 18, 1925, in Milwaukee, he graduated from the Northwestern University School of Medicine in 1950. He served his internship at St. Luke's Hospital, Chicago, and his residency at University Hospital in Ann Arbor, Mich. Doctor Sproule served in the United States Naval Reserve.

He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two sons, Ralph and Phillip; and two daughters, Karen and Janet.

Edward F. Barta, MD, 82, Wauwatosa, died Nov. 5, 1971, in Milwaukee.

Born on Feb. 12, 1889, in Casco, Wis., Doctor Barta graduated from Marquette University School of Medicine in 1913 and also served his internship there. In 1914, he joined the staff of Marquette University School of Medicine, became a professor of pathology and was named professor emeritus upon his retirement in 1959. Doctor Barta also maintained a private practice from which he retired in 1964. He served on the staffs of St. Michael, St. Anthony's, and Deaconess hospitals.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and Wisconsin Society of Pathologists.

Surviving are his widow, Martha; and one daughter, Mrs. Arnold J. Menahlo, Sheboygan; two sons, Dr. Richard F. and William E., Elm Grove, Wis.

James W. McGill, MD, 72, prominent Superior physician for over 40 years, died Nov. 8, 1971, in Superior.

Born July 2, 1899, in Superior, he graduated from St. Louis University School of Medicine in 1925 and served his internship at St. John's Hospital in St. Louis, Mo. He was in practice with his father, the late Dr. P. G. McGill, until 1930 and then maintained his office until the opening of the Superior Clinic in 1965. He was a member of the medical staff and former chief of staff of both St. Mary's and St. Joseph's hospitals in Superior. He was local surgeon for The Northern Pacific, Soo Line, and Northwestern Railways, physician for St. Joseph's Children's Home, and medical officer for Wisconsin National Guard.

Doctor McGill was an outstanding citizen and member of many professional organizations. In 1955, he was conferred with the "Knight of the Order of St. Gregory the Great" by Pope Pius XII, and in 1966 he received the B'nai B'rith sponsored outstanding citizen award.

He served as a delegate to the State Medical Society of Wisconsin from Douglas County Medical Society and was also a member of the State Medical Society's committees on cancer and federal legislation. Doctor McGill was a member of the Central Association of Obstetrics and Gynecology and American Academy of Obstetrics and Gynecology. A past president of the Douglas County Medical Society and Interurban Academy of Medicine, he was also a member of the American College of Surgeons and American Medical Association.

Surviving are his widow, Mary; two sons, James Jr., Waukesha, and John, Baytown, Tex.; and one daughter, Mary Kay, Superior.

George H. Stevens, MD, 75, prominent Wausau physician for 42 years, died Nov. 9, 1971 in Wausau.

Born Aug. 21, 1896, in Boone, Iowa, he graduated from the University of Iowa School of Medicine and served his internship at Henry Ford Hospital, Detroit, Mich. Doctor Stevens served as president and secretary of St. Mary's Hospital as well as chief of the obstetrics department. He also was on the medical staff of Memorial Hospital (now Wausau Hospital South).

He was past president of the Wisconsin Society of Obstetricians and Gynecologists, past president and secretary of the Marathon County Medical Society, and a member of the Division on Maternal and Child Welfare of the State Medical Society of Wisconsin. Doctor Stevens also was a member of the Wisconsin Society of Family Physicians and American Medical Association.

Surviving are his widow, Grace; a daughter, Mrs. Robert Schmidt, Wausau; and two sons, Dr. George E., Washington, D.C., and Richard J., Chippewa Falls.

William Davison Stovall, MD, 84, a longtime state medical leader, died Nov. 18, 1971, in Madison.

A pioneer in the State Laboratory of Hygiene which he directed for 44 years, Doctor Stovall also was a leader in the State Medical Society of Wisconsin and the American Medical Association, the American Cancer Society and its Wisconsin Division, and the University of Wisconsin Medical School.

Doctor Stovall was born Oct. 31, 1887, in Longtown, Miss., and was a fourth generation physician in his family. He graduated from Mississippi College in 1908 and received his medical degree from Tulane University in 1912. He came to Wisconsin in 1914 and the following year became director of the State Laboratory of Hygiene.

Doctor Stovall's career is aptly told in a tribute published in the State Laboratory of Hygiene's LABORATORY NEWSLETTER of December 1971, excerpts of which follow:

"When Dr. Stovall took over the directorship (of the State Laboratory of Hygiene which opened October 1, 1903), he expanded the activities of the Hygiene Laboratory to meet the needs of the practicing physicians; he was always anxious to offer new tests as they became available. One major goal he set for the Laboratory was to assure all physicians, even those in remote rural areas, that they would be able to enjoy the benefits of the latest scientific services. . . . When the science of clinical virology developed, Dr. Stovall was one of the first to start a virus department in a public health laboratory.

"Because of his knowledge and helpful attitude, doctors throughout the state often called on Bill Stovall for consultation and advice. Under his direction, the Laboratory expanded and flourished. Even though he was involved in numerous administrative activities, he always managed to work several hours each day at the bench.

"As the volume of work increased, it became necessary to open cooperative laboratories in Beloit, Green Bay, Kenosha, Oshkosh, Rhinelander, Superior, and Wausau. Supervision of these branch laboratories placed more responsibility on Dr. Stovall; yet in 1946, he undertook a

major new activity, namely, the provision of cancer cytology services, and mounted a major program in uterine cancer detection. When the Psychiatric Institute was reorganized, the Laboratory of Hygiene assumed syphilis serology testing and blood chemistry testing.

"Responsibility as director of the Wisconsin State Laboratory of Hygiene constituted only a portion of Dr. Stovall's activities. He was also a professor of hygiene and medicine in the University of Wisconsin Medical School, and as such he took an active role in teaching medical students, nurses, and medical technologists. Starting in the 1920's, he conducted a course in clinical laboratory diagnosis for second-year medical students. He taught courses in hygiene to nursing students and fourth-year medical students. He was in charge of the medical technologists program, and later developed a training school in cytotechnology.

"When the Wisconsin General Hospital was opened in 1924, Dr. Stovall became director of all the clinical laboratories, in addition to directing the Hygiene Laboratory. For a few years (1938–1940) he was even acting superintendent of the hospital. He continued to carry out all these responsibilities until his retirement (as director of the Laboratory) in 1958.

". . . He contributed his endless energy to many other activities at the local, state, and national levels. Bill Stovall was a natural leader. In meetings and on the speaker's platform, he always presented the picture of a scholarly, dignified physician. He had the ability to fascinate audiences by his colorful style of delivery which through the years retained the southern drawl of his native Mississippi.

". . . A major interest of Dr. Stovall was cancer control. He devoted much effort to cancer education, early diagnosis, and effective treatment. In 1935, he co-founded the Wisconsin Division of the American Cancer Society. He served for many years on its Board of Directors and was the first Board Chairman after the reorganization of the Division. In 1948 he received the first Annual Distinguished Service Award. His interest in cancer control led Dr. Stovall to start the first School of Cancer Cytology in Wisconsin, at the State Laboratory of Hygiene, and to carry out a large uterine cytology demonstration program in 14 rural counties (1956–1959).

"For many years, Dr. Stovall served on the State Board of Public Welfare and was its chairman for several terms. He was a consulting pathologist to two hospitals in Madison, St. Mary's and Madison General Hospital . . . a member of the advisory board to the Madison Visiting Nurse Association . . . an honorary member of the Public Health Nurses Association. In addition, Dr. Stovall was a member of many other professional, literary, and scientific organizations. Because of his contributions and long service to the Wisconsin Board of Public Welfare, a new geriatric wing at Mendota State Hospital was named Stovall Hall. Certainly, William D. Stovall will long be remembered for the many contributions he made to the health and welfare of Wisconsin for over half a century."

Many honors were bestowed on this great man of medicine. In 1940 Doctor Stovall was the recipient of the State Medical Society's Council Award, the highest honor accorded by the Society. He served as the Society's president in 1948 and was a member of the American Medical Association's House of Delegates for 16 years (1942–1958).

A commemorative entrance to the State Medical Society's Madison headquarters was dedicated in his honor in 1958, a project of the Dane County Medical Society in which he had served as president and held other offices.

In 1961 the *Wisconsin Medical Journal* published a special "festschrift" issue in his honor, containing tributes by state and medical leaders, several of them his former students.

His lifelong interest in medicine led to his election as president of the State Medical Society's Charitable, Educational and Scientific Foundation in 1958, a position he held until he became president emeritus in May 1971. His concern for the preservation of medical history was a motivating force in the development of the Museum of Medical Progress in Prairie du Chien, a Society project administered through the Foundation.

Doctor Stovall's important contributions to the health of Wisconsin's residents were recognized by the Society in 1962 when it named the Stovall Hall of Health at the Museum in his honor.

In his later years Doctor Stovall was active in both the University of Wisconsin and the State Medical Society. Upon his retirement from the University in 1961, he became a special assistant to the medical school dean and spent a good deal of time touring the state on university business. He was the recipient of the UW Emeritus Faculty Award in 1964.

The CES Foundation trustees in December established a memorial fund in his honor. All members of the Society were invited to contribute to the fund, not to be restricted to any particular activity but rather to further the efforts of the Foundation in student loans, scientific lectures, historical projects, and any "endeavor that would be in scope as large as were Doctor Stovall's interests in his profession."

Survivors include his sister, Mrs. Joaddie West, Nashville, Tenn.; brother, Jack, Memphis, Tenn.; daughter-in-law, Mrs. Janice Stovall, Madison; and two granddaughters, Mrs. Robert Easton, Providence, R.I.; and Victoria Stovall, Madison.

Robert I. Sorenson, MD, 42, Milwaukee orthopedic surgeon, died Nov. 23, 1971, in Milwaukee.

Born on May 18, 1929, in Elkhorn, Doctor Sorenson graduated from Northwestern University School of Medicine, Chicago, in 1955 and served his internship and residency at the United States Naval Hospital in Oakland, Calif., for five years. He also was located at Kernan Crippled Children's Hospital, Baltimore, United States Naval Hospital in Charleston, S.C., and in Memphis, Tenn.

Doctor Sorenson was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mary, and four children.

Hartwick M. Stang, MD, 83, co-founder of the Midelfort Clinic, Eau Claire, died Nov. 29, 1971, in Eau Claire.

Born Mar. 2, 1888, in Eau Claire, Doctor Stang was a graduate of the Harvard Medical College in 1919 and interned at the Hartford Hospital, Hartford, Conn. He did postgraduate work at the New York Postgraduate Hospital. Doctor Stang was associated with the Midelfort Clinic for 28 years and was a medical consultant with the Gundersen Clinic for three years before his retirement.

Doctor Stang served as a councilor from the 10th district for six years, was president of the Eau Claire–Dunn–Pepin County Medical Society, president, secretary, and treasurer of the Wisconsin Urological Society, served as a member of the Executive Council of the American Urological Society for 12 years, was a past president of the North Central Section American Urological Society and was a preceptor of the University of Wisconsin Medical School. He was a past president of the medical staff of Lutheran Hospital, Eau Claire, and a member of the medical staff of Sacred Heart Hospital. Doctor Stang also was a member of the American College of Surgeons and the American Medical Association.

Surviving are his widow, Edythe, and one daughter, Mrs. Thomas Spencer, Seattle, Wash. □

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TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
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T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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(1) The onset of action of T_4 is gradual. It has a long in vivo "half-life" of over six days. (Occasional missed doses or accidental double-doses are of les concern because of this factor)[1]; (2) since SYNTHROID contains onl T_4, the potential for metabolic surges traceable to more potent iodides (T_3) is eliminated.

AS WITH ANY THYROID PREPARATION, CAUTIOUS OBSERVATION OF THE PATIENT DURING THE BEGINNING OF THERAPY WILL ALERT THE PHYSICIAN TO ANY UNTOWARD EFFECTS.

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yroxine (T_4) is, as you know, e major circulating hormone oduced by the thyroid gland. , is also produced, in smaller nounts, and is active at the llular level. For years it has been working hypothesis among ndocrinologists that T_4 is nverted by the body to T_3. In 970 this process, called deiodination," was demonstrated / Braverman, Ingbar, and Sterling[2]. , does convert to T_3, though the ecise quantities are still being udied.

The conversion has been inically demonstrated during the dministration of T_4 to athyrotic atients. Their thyroid status is rmalized on SYNTHROID alone, t the presence of T_3 in these atients has been clearly shown.

WHY DOES SYNTHROID COST LESS THAN SYNTHETIC DRUGS CONTAINING T_3?

Very simple. T_3 costs more to make synthetically than does T_4. So it is economically necessary for a synthetic thyroid medication containing T_3 to cost more than one containing T_4 alone. Synthetic combinations cost patients nearly 50% more than SYNTHROID[3] because the T_3 costs more to start with; also there is the additional expense of formulating a tablet containing two active ingredients.

1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.
2. Braverman, L. E., Ingbar, S. H., and Sterling, K.: Conversion of Thyroxine (T4) to Triiodothyronine (T3) in Athyreotic Human Subjects, *J. Clin. Invest.* 49:855-64, 1970.
3. American Druggist BLUEBOOK, March, 1971.

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Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

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Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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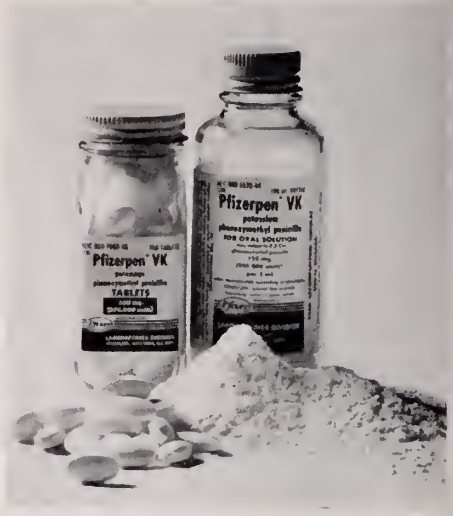

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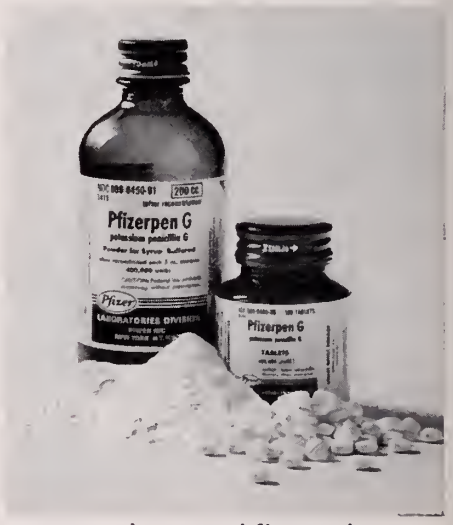
500 mg. (800,000 units): bottles of 100.



Butterscotch-caramel-flavored Pfizerpen G Powder for Syrup (potassium penicillin G)
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Pfizerpen G Tablets (potassium penicillin G)
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DEATHS

Strass, Herbert W., Milwaukee County, Sept. 10, 1971
Werts, Kenneth G., Waukesha County, Sept. 15, 1971
Sorenson, Robert I., Milwaukee County, Nov. 23, 1971
Stang, Hartwick M., La Crosse County, Nov. 29, 1971
Gilchrist, Ralph T., Milwaukee County, Dec. 17, 1971
Huber, Gale W., Oneida–Vilas County, Dec. 18, 1971
Kovacs, Madeline, nonmember, Dec. 18, 1971
Geiger, Sara G., nonmember, Dec. 21, 1971
Schulz, Gordon J., Racine County, Dec. 26, 1971 □

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Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

the wisconsin medical journal

ANNUAL MEETING PROGRAM

SEE DETAILS ON PAGES 17 26

ote April 4. Society supports passage of referenda question on medical examiner. Details in GREEN SHEET

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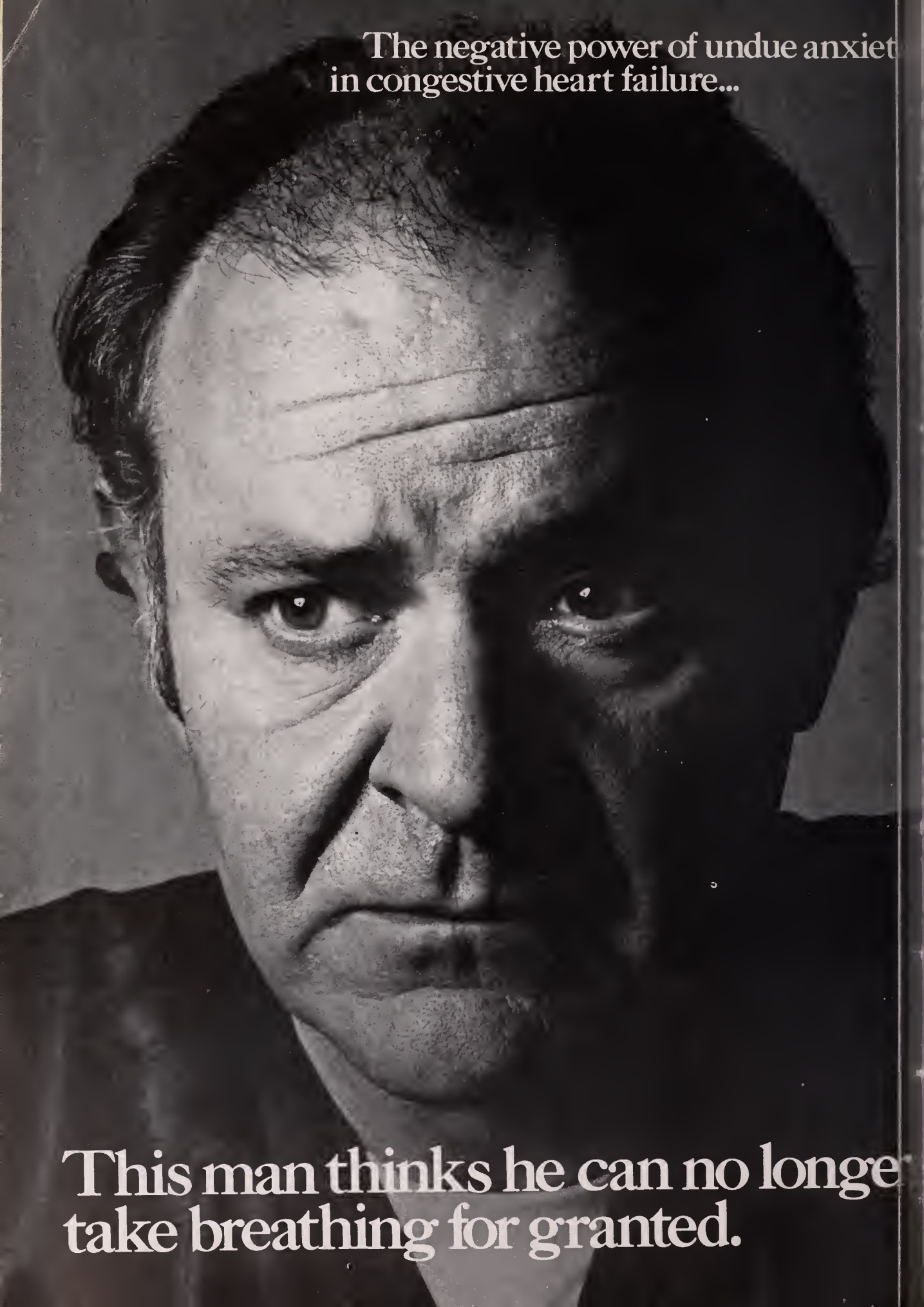
The negative power of undue anxiet
in congestive heart failure...
This man thinks he can no longe
take breathing for granted.

Typical of many patients with congestive heart failure, he also suffers from severe anxiety, a psychic factor that may influence the character and degree of his symptoms, such as dyspnea. His apprehension may also deprive him of the emotional calm so important in maintenance therapy.

Aid in rehabilitation
Specific medical and environmental measures are often enhanced by the antianxiety action of adjunctive Libritabs (chlordiazepoxide). Libritabs can also facilitate treatment of the tense convalescent patient until antianxiety therapy is no longer required. Whereas in geriatrics the *usual daily dosage* is 5 mg two to four times daily, the *initial dosage* in elderly and debilitated patients should be limited to 10 mg or less per day, adjusting as needed and tolerated.

Concomitant use with primary agents
Libritabs is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics, antihypertensives, vasodilators and oral anticoagulants, whenever excessive anxiety or emotional tension adversely affects the clinical condition or response to therapy. Although clinical studies have not established a cause and effect relationship, physicians should be aware that variable effects on blood coagulation have been reported very rarely in patients receiving oral anticoagulants and chlordiazepoxide HCl.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal*, as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal*. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

PRESIDENT'S PAGE

Why Belong to the State Society and the AMA?

THERE IS ONE VERY POSITIVE and direct answer to this question. Your State Society and the AMA represent the entire medical profession. What other medical professional society is made up of generalists and specialists, young and old, conservative and liberal, Republican and Democrat, and tries to represent all the diverse opinions therein? To quote from the *Worchester Medical News* of January–February 1972, "The AMA receives criticisms for most health problems but does not receive the support of all of the healers. The AMA ahead of any specialty organization, has addressed itself to a wide variety of crucial health problems, i.e., death and injury from automobile trauma, drug abuse, and venereal disease. Have the American 'Academies' of Dermatology, Radiology, Orthopedics, Endocrinology, Nuclear Medicine, Obstetrics and Gynecology, etc., for example, engaged in studying the dimensions of drug abuse, truly a national scourge?" Specialty organizations, including Family Practice, do not represent all doctors; they do not address themselves to the wide variety of crucial health problems. Although influential, they have not been primary guiding influences in raising medical educational standards, hospital accreditation, and many other medical problems. They have not been the prime leaders on the total range of legislative problems. Many physicians now engaging in specialty medicine are identifying with their specialty organization. The medical profession has become fractionated.

Constant criticism of health care from an endless army of consumers has contributed to a profound attitude of apathy and rejection within the medical profession. I certainly do not agree with everything that our Society or the AMA has done, but I have tried to effect some change and influence to improve their functions.

Medicine organized originally to improve its professional status, elevate its professional training, and meet the many problems of health care. Organized medicine still functions in these areas and has expanded to many other fields. Their activities in the socio-economic field have brought the greatest criticism both from outside and within the profession. If the State Society and the AMA are to bear the entire brunt of this critcism, then it should be put at the helm of all medical professional organizations with full membership of all physicians.

The State Medical Society and the AMA are still the only organizations that speak for the entire profession. If every physician was a member and active, the State Society and the AMA would more accurately reflect the majority viewpoint.

G. A. Behnke M.D.

G. A. BEHNKE, MD

P. S. On Wednesday, May 10, during the Annual Meeting in Milwaukee, the Long-Range Planning Committee of the AMA will hold all-day, open hearings. All members are urged to appear and present their views pro and con about any phase of AMA activity.

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Competency in Medicine

TIME WAS WHEN COMPETENCY in the practice of medicine was assumed. Graduation from medical school, internship, and years of practice enabled one to feel sure of doing what was best for the patient and most effective in reversing the course of disease. In the last decade we have witnessed a curious paradox.

On the one hand there is a sudden broadening of the base of treatment as it is seen by the public. This comes from increased response to misinformed "consumer demand" which has been transposed, for example, into a law mandating payment for chiropractic services under workmen's compensation. The same "demand" is being used to create a climate for passage of Senate Bills 202 and 203 bringing chiropractic services into health insurance plans and Medicaid.

In the specialty of psychiatry, it is not necessary for a psychologist or other psychotherapists such as marriage consultants, social workers, or ministers to have medical supervision in order to practice. Other forms of special medical service are being rapidly recognized as existing relatively or entirely free of physician supervision. Perhaps free from medical judgment would be a better way to put it. In fact even in medicine, the finely defined procedures are taking on a reality of their own, apart from medical judgment.

In California we have Medi-Cal, and its jargon reads like this in regard to payment for psychiatric services. Can you follow it?

> "Emergency visits require no prior authorization, however, provided they are adequately documented on Service Report form MC-163. This, of course, is to be distinguished from form MC-180, which was used to justify authorization for continuation of an emergency hospitalization beyond the 8th day, provided the attending physician had received verbal approval from the Medi-Cal consultant by phone.
>
> "The consultant is guided in his decision by length of stay 'norms.' These currently are 10 days for non-organic psychoses, 7 days for alcoholism or drug dependence, and 4 days for brain syndromes, alcoholic psychoses, neuroses or personality disorders. And this consultant himself was subject to audit and reversal at higher levels of Medi-Cal hierarchy.
>
> "When prescribing medication, the practitioner had to use drugs on the Medi-Cal Formulary, which once excluded all tranquilizers and anti-depressants except chlorpromazine. He could deviate from the Formulary if he documented his request to do so on form MC-161, and same was approved.

"The California Medical Association brought a class action suit against the administrators of the program on behalf of all Medi-Cal recipients and practicing physicians, claiming that the above outlined restrictions deny recipients 'necessary and adequate medical care,' and requires physicians to render care below acceptable standards of good medical practice.

"The California Superior Court enjoined the administrating agency from enforcing the above regulations. The agency appealed but subsequently relaxed some of its restrictions."

Where is medical judgment in this story?

In contrast to all this fragmentation and specification we face the need to establish some method to raise standards of competency. Peer review has become commonplace, in hospital surgical review boards, and about problems such as length of stay for medical cases and extension into convalescence, and the like. Charts are checked for "proper" information to indicate if competency exists. But who does this? The answer usually is that this judgment is made by the physicians who also practice, and who have the longest staying power at staff and committee meetings, and who thereby reach these proper positions. Whether this is popularity is moot; usually popularity wanes for the doctor who exercises too sharp judgment.

There is some attempt to study the *process* of judging competency. One current example is the paper by Fessel and Van Brunt, from the Permanente Group, which appears in the January 20, 1972, *New England Journal of Medicine*. This is a report on the predictability of results from chart reports of two common conditions, appendicitis and myocardial infarction, and is entitled: "Assessing Quality of Care from the Medical Record." The first condition showed correlation between chart content and outcome, while the records of myocardial infarction gave no information about time lost, complications, and the like. Some groups place their confidence in continuing education as a measure of competency. Several doctors were dropped recently from the medical society of a western state. They did not lose their licenses but were dropped from medical society membership for failure to participate in the 50-hour a year "keeping up" program of medical education. Many groups, like our own Wisconsin Regional Medical Program, are attempting a serious study of the educational factors that are involved in continued training of physicians. California recently sent a questionnaire to all licensed physicians asking whether the individual was currently enrolled in a program of on-going education. This was stated as preparatory to action by the California Medical Association aiming toward some possible requirement about licensing.

And the real problem remains as to just which persons will do the judging and the teaching. Should it be the professors in the medical schools? Many are highly skilled researchers and most do some teaching and some do have clinical skill. Should it be the practitioner who has the largest practice? This would be evidence of successfully conveying to large numbers of people that some skill or value rests in his clinically experienced person. Should it be the elected chiefs-of-staff? This would indicate some sort of peer judgment. A troika composed of one of each of these three might prove unmanageable. Perhaps the Medical Society itself could assume responsibility for these new directions, tightening up on standards on the one hand, and maturely accepting the relaxing of standards on the other hand through accepting lesser trained personnel on the health care team. It may be that to manage such a conglomerate affair will require political skill, which could then parcel out bits of the job to town and gown. It is fascinating, and profoundly disturbing, to watch the simultaneous easing and tightening of health care standards. Maybe if we all are aware of the dichotomous pressures, we can more nearly arrive at a solution mutually satisfactory for ourselves and our public. Right now it seems the public is riding madly in two separate directions at once.—RH

Nothing Succeeds Like Charisma

For those of us who wonder how the chiropractors manage to upstage physicians, no better example can be found than the following direct quotation from the *Milwaukee Journal*, Feb. 22, 1972. The article reported that a representative of the State Medical Society spoke in favor of the physician's assistant bill saying that "agreement had almost been reached between the society and other professional groups on the conditions under which medical assistants should be used." The news story then went on:

"Chiropractors did not appear to be among those with whom agreement had almost been reached Monday. Carl Lauri, representing the Wisconsin Chiropractic Association, said 'The association supports health care programs as much as anybody.'

"But he said not enough was known about how well medical assistants worked out.

"Lauri said: 'Assistants shouldn't be doing things other professionals are licensed to do.'

"He said he was 'afraid patients will have to pay both a doctor and an assistant for some medical care.'"

—RH □

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Warnings: *Drug Dependence:* Physical and psychological dependence and abuse have occurred. Chronic intoxication, from prolonged use and usually greater than recommended doses, leads to ataxia, slurred speech, vertigo. Carefully supervise dose and amounts prescribed, and avoid prolonged use, especially in alcoholics and addiction-prone persons. Sudden withdrawal after prolonged and excessive use may precipitate recurrence of pre-existing symptoms (e.g., anxiety, anorexia, insomnia) or withdrawal reactions (e.g., vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis; rarely convulsive seizures, more likely in persons with CNS damage or preexistent or latent convulsive disorders). Therefore, reduce dosage gradually (1-2 weeks) or substitute a short-acting barbiturate, than gradually withdraw. *Potentially Hazardous Tasks:* Driving a motor vehicle or operating machinery. *Additive Effects:* Possible additive effects between meprobamate, alcohol, and other CNS depressants or psychotropic drugs. *Pregnancy and Lactation:* Safe use not established; weigh potential benefits against potential hazards in pregnancy, nursing mothers, or women of childbearing potential. Animal data at five times the maximum recommended human dose show reduction in litter size due to resorption. Meprobamate appears in umbilical cord blood at or near maternal plasma levels, and in breast milk at levels 2-4 times that of maternal plasma. *Children Under Six:* Drug not recommended.
Precautions: To avoid oversedation, use lowest effective dose, particularly in elderly and/or debilitated patients. Consider possibility of suicide attempts; dispense least amount of drug feasible at any one time. To avoid excess accumulation, use caution in patients with compromised liver or kidney function. Meprobamate may precipitate seizures in epileptics.
Adverse Reactions: *Central Nervous System:* Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity. *Gastrointestinal:* Nausea, vomiting, diarrhea. *Cardiovascular:* Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case). *Allergic or Idiosyncratic:* Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/carbromal. More severe, rare hypersensitivity: hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids). *Hematologic:* Agranulocytosis and aplastic anemia (rarely fatal), but no causal relationship established. Rarely, thrombocytopenic purpura. *Other:* Exacerbation of porphyric symptoms.
Usual Adult Dosage: 1200 to 1600 mg daily, in three or four divided doses; doses above 2400 mg daily not recommended.
Overdosage: Suicidal attempts with meprobamate, alone or with alcohol or other CNS depressants or psychotropic drugs, have produced drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse, and death. Empty stomach, treat symptomatically; cautiously give respiratory assistance, CNS stimulants, pressor agents as needed. Meprobamate is metabolized in the liver and excreted by the kidney. Diuresis and dialysis have been used successfully. Carefully monitor urinary output; avoid overhydration; observe for possible relapse due to incomplete gastric emptying and delayed absorption. REV. 10-71

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COUNCIL MINUTES—State Medical Society of Wisconsin

MADISON, NOVEMBER 18, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:30 p.m. at the Society.

Voting members present: Doctors Schrank, Galgano, Nordby, Davenport, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Williams, Egan, Foley, Schmidt, Meyer, President Behnke, and Speaker Nereim.

Others present: President-elect Purtell; Doctors Collentine, Galasinski, Carlson, Twelmeyer, Russell, and Kief, AMA delegates and alternates; Doctors Headlee and Handy; Doctors Leonard and Schneider for special order; Messrs. Thayer, Maroney, Brower, Reynolds, Johnson, LaBissoniere, Kastner, Gill, Murphy, Kluwin, Tiffany; Miss Pyre.

2. Approval of Minutes

By separate motion made, seconded and carried, minutes of the July 31 and October 23 meetings of the Council were approved.

3. Perinatal Health Care Authority—SB 597

Drs. T. A. Leonard and J. M. Schneider appeared to request Council reconsideration of its present position in reference to this bill aimed at improving the quality of health care, especially hospital care, for expectant mothers and newborn infants. Hospitals supplying such care would be required to meet criteria established by a perinatal care authority.

Doctor Nordby reiterated the Council's objections to establishing such a program through legislation and to the proposed method of financing.

After discussion, on motion of Doctors Mauthe–Lewis, carried, the Council asked that the Executive Committee attempt to work out an acceptable alternative with Doctors Leonard and Schneider.

4. Report of Committee on Economic Medicine

(a) Professional Liability Insurance

The committee presented a report in detail on the results of the membership survey and meetings held with some of the insurance companies who had indicated an interest in providing professional liability insurance to members under some form of Society sponsorship. The committee pointed out that almost without exception individual risk selection is involved in various so-called "group" professional liability insurance programs, and therefore suggested that any considerations along these lines should be regarded and referred to as Society *sponsored* activities rather than as a *group* program.

The committee felt it had not had sufficient time to consider fully the many and varied problems involved and requested additional time for continued studies and negotiations so as to be able to make more definite recommendations at a later date. It asked for an expression from the Council on the following:

1. A decision as to whether or not the committee should pursue its endeavors toward the ultimate development of a professional liability insurance program under Society sponsorship—(the respondents to the survey did not indicate a clear mandate in this regard);

2. If in the affirmative, the committee be authorized and empowered to proceed to the point of developing a suggested program of activity subject to Council (and possibly House) approval prior to implementation; and

3. That a summary of the committee's report be prepared and distributed on behalf of the Council to the component county societies in accordance with Resolution Q of May 1971.

On motion of Doctors Egan–Mauthe, carried, the Council approved the report of the Committee on Economic Medicine including the three recommendations above.

(b) Review of All Insurance Programs for Society Members

On motion of Doctors Mauthe–Galgano, carried, the Council requested that henceforth any new programs or changes in existing programs be reviewed by the Committee on Economic Medicine before implementation, including the health insurance program for members which heretofore has been reviewed only with the Commission on Medical Care Plans.

(c) Broker of Record

Some years ago the Society named Seefurth–McGiveran as its "broker of record in connection with present, new, or additional group insurance coverage put into effect by us for our employees and/or members of the Society, until further notice." The company has inquired as to its involvement in negotiations for a professional liability program. It was pointed out that the committee has been receiving presentations directly from the various carriers and it could well be that any given proposal would be altered or withdrawn if these companies were compelled to work through a specific broker.

On motion of Doctors Schrank–Mauthe, carried, the Council directed that Seefurth–McGiveran be advised that its involvement in professional liability insurance is not desired at this time.

5. Report of AMA Delegation

Doctor Galasinski reported that information had been received that one reference committee at the forthcoming clinical convention would devote itself entirely to the question of the AMA calling a Constitutional Convention. He asked for direction from the Council as to the position to be taken by the Wisconsin delegation.

After discussion, on motion of Doctors Rohde–Edwards, carried, the Council endorsed the need for a Constitutional Convention.

On further motion of Doctor Schrank, seconded and carried, the Council asked that all members be notified of this action and informed of their right either to appear before the AMA reference committee or make their wishes known by letter to the delegates.

6. Report of Finance Committee

Doctor Dettmann reported generally on the committee's review of 1971 budget performance and prospects for 1972, and requested Council action on the following items concerning the Society and its employee pension plan:

(a) *Wisconsin Medical Journal*

On motion of Doctor Dettmann, seconded and carried, the Council established $5.00 (from dues) as the subscription rate for members, and $10.00 for non-members.

(b) North Central Conference Expense

On motion of Doctors Dettmann–Egan, carried, the Council authorized reimbursement of expenses for Doctor McRoberts to attend two AMA meetings as President of the North Central Conference.

(c) Vesting Rights Under Original Pension Plan

The committee reported its review of the pension plan's provisions for vesting of Society contributions as they

apply to the employee, both prior to and after December 31, 1969, the date of the changeover to the present revised plan. The original plan established a formula for vesting of part or all of the Society's contributions after a certain number of years of participation in the plan. Under the revised plan none of the Society's contributions made after 1969 are vested in the participant. Instead they will be represented by his pension benefit at retirement.

The committee, as trustees of the plan, agreed that the plan's intended purposes would better be achieved by provision for 100% vesting of the withdrawal benefit under the original plan for those participating prior to January 1, 1970, including those who had severed Society employment before that date. After hearing a report that the Finance Committee had been advised by Messrs. Tiffany and Dodge that this approach was actuarially sound, the Council approved adoption of this interpretation on motion of Doctors Dettmann–Smejkal, carried.

On further motion of Doctor Egan, seconded and carried, the Council authorized legal counsel to implement any necessary amendment of the plan with the Internal Revenue Service to accomplish this intent.

7. Quarterly Report of Commission on Medical Care Plans

The following report was received by the Council on motion of Doctor Egan, seconded and carried:

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS TO THE COUNCIL—OCTOBER 30, 1971

The July CMCP Report to the Council included detail regarding an approved experimental "Health Maintenance Program" then under discussion within several county medical societies. Since that time, a number of meetings have been held with the Dane County Medical Society out of which have come suggested changes to adapt the program to the specific characteristics of medical practice in the area. The plan contemplates a combination of fee for service and fixed monthly payment to physicians, anticipating that the experimental plan will provide some reliable data on which to base a comparison with current health insurance programs available in the area. For example, it should provide more firm information on the question of whether the availability of a broad range of "out of hospital" benefits does result in a measurable reduction in insurance costs for hospital services.

A contract benefit for sterilization procedures is still under consideration by the Commission. A meeting has been held with representatives of one county society which takes the firm position that *all* sterilization procedures should be covered. The cost impact in the absence of specific premium increase to cover the benefit is just one question involved. Another is whether benefits for sterilization procedures performed on request of a subscriber are properly included within an insurance contract.

The WPS September Financial Statement, already distributed to the Council, shows continued favorable results during the year. Adequate reserves have been established to cover claims not yet reported for services already rendered.

A full day's session of the Work Week of Health was dedicated to the subject of health insurance in recognition of WPS' 25th Anniversary. The services of members of the CMCP were recognized at a luncheon, during which the National Association of Blue Shield Plans presented a plaque commemorating the 25th Anniversary, stating:

"In recognition of 25 years of outstanding performance in the field of Voluntary Prepaid Medical Services, and for successfully meeting the needs of the public and the Medical Profession in the finest Blue Shield tradition."

George Dunlop, MD, Vice Chairman of the National Board who made the presentation, cited WPS as "showing the concern of the profession for delivery of medical care to the people at a reasonable cost."

The Commission has approved the renewal of a two-year contract with the Office for the Civilian Health and Medical Program of the Uniformed Services—an extension beyond the previous one-year commitment.

The Governor has signed into law a bill to be effective for the year beginning January 1972, which results in an income tax on the Blues in Wisconsin. Still to be finally determined will be those categories of reportable income and allowable expense in determining net income subject to such taxation. The percentage will vary consistent with current corporate tax levels from approximately 2 to 8 per cent on net income. This is in effect an additional sales tax since it must be passed along to WPS subscribers in the form of higher rates. However, from the standpoint of both subscribers and the Blues it is a more favorable approach than a premium tax.

These represent the more important items that should be of interest to the Council with which the Commission has been involved since its July report.

Respectfully submitted,

(signed) E. M. Dessloch, MD
Chairman, Commission on Medical Care Plans

8. Health Care Review, Inc.

Mr. Brower reported on the status of discussions with the Wisconsin Hospital Association and the Wisconsin State Dental Society, both of which have already approved in principle the development of and participation in a health care review organization. He also outlined suggestions of the Dental Society for incorporation in the draft Articles and Bylaws which are still under negotiation. By early December there would be opportunity for each to reach a decision on incorporating. Staff therefore recommended that:

(a) the incorporation of Health Care Review, Inc., be authorized and completed before the end of the calendar year;

(b) negotiations continue on suggestions of the Dental Society along the lines discussed with the Council;

(c) there be a minimum of three incorporators, and that the WSDS and WHA be invited to designate an incorporator to serve in that capacity along with a representative of the State Medical Society;

(d) if for any reason incorporators are not designated by the other organizations, the activity be incorporated by a person or persons suitable to the Council or to be named by an ad hoc committee with authority to proceed; and

(e) appropriate notification and publicity be given to the existence of the new corporation as well as the availability of its services to all legitimate interests.

By separate motions made, seconded and carried, each of these recommendations was approved by the Council.

Mr. Brower further stated it has been understood that the Society's present Utilization Advisory Committee will perform the peer review function for the medical profession.

Mr. Thayer reported that the Department of Health and Social Services had requested a meeting with staff to discuss ways in which the Society might aid in conducting a review of facilities and services in nursing homes and the colonies in connection with the operation of Title 19, and that the Health Care Review organization might prove to be the mechanism for this and other purposes.

9. Reports of Consultants

There were reports for information from Messrs. Kluwin, Gill, and Tiffany on the kinds of activities they are engaged in as Council-appointed consultants to the Society and its divisions.

10. Publication of "A Guide to the Medical Management of Acute Mind-Altering Drug Reactions"

On motion of Doctor Galgano, seconded and carried, the Council approved the recommendation of the Divisions on Nervous and Mental Diseases and Alcoholism and Addiction that this guide be published by the Society and provided at cost, except that it be distributed without cost to hospital emergency rooms and student health services in Wisconsin.

11. Report of Executive Committee

(a) Review and Updating of SMS Constitution and Bylaws

The Executive Committee recommended, without suggesting any urgency, that a committee begin the job of modernization, clarification and simplification of the Society's Constitution and Bylaws.

On motion of Doctor Behnke–Egan, carried, the Council referred this to the Planning Committee with authority to expand itself as deemed necessary for the purpose.

(b) "Physician of the Week"

The Executive Committee discussed President Behnke's recommendation to the special session of the House of Delegates in October that one volunteer physician be present each week at the Capitol while the Legislature is in session. This is intended as an educational experience for the physician who can then relate it to local physicians. The committee recommended that this be tried experimentally for the remainder of the session reconvening in January.

On motion of Doctors Heinen–Mauthe, carried, the Council approved implementation of the program after details have been worked out.

(c) Sponsorship of Radio Program on State Broadcasting Service

The Executive Committee recommended approval of the request of State Radio Station WHA that the Society share sponsorship of statewide expansion of the "Dear Doctor" program now carried by WZMF. Alan Reed, Jr., MD, a Society member, speaks and responds to phone calls from primarily youthful listeners. Cost would be that of a WATS line at $225 per month, or part of that amount if the State Radio Council also contributes.

On motion of Doctor Edwards, seconded and carried, the Council approved the recommendation with a one-year commitment.

(d) Study of Emergency Care in Wisconsin

The committee recommended that there be referred to the Commission on Hospital Relations and Medical Education, with authority to implement, a joint effort with the Wisconsin Hospital Association and the Division of Health to update a 1968 study and report on emergency room facilities and services available in the state.

On motion of Doctors Behnke–Smejkal, carried, this recommendation was approved.

(e) Laboratory Licensing Legislation

The committee reported that David LaFond, MD, had met with it to discuss a proposed compromise version of a laboratory licensing bill first introduced in 1969. The changes were outlined which had been approved by the Commission on Public Policy, and the Executive Committee recommended approval of the Council and efforts to have it passed in this session if possible, or in 1973.

On motion of Doctor Egan, seconded and carried, this recommendation was approved.

12. Ad Hoc Committee on Annual Meeting

Doctor Foley reported on the initial meeting of this committee in which one specific suggestion was made that members of the Commission on Scientific Medicine be permitted to serve three terms of three years rather than the present single five year term. He indicated that further study was needed as to financial aspects of the Annual Meeting. This was accepted as a progress report and the committee was asked to report later with specific recommendations as to bylaw amendment and other matters.

13. Executive Session

NOTE: Minutes of the executive session will be read at the next meeting for Council action.

14. University of Wisconsin President John C. Weaver

President Weaver met with the Council for informal discussion relating to the merger of the University system, the future of medical education, and the like.

15. Adjournment—5:30 p.m.

EARL R. THAYER
Secretary

Approved Feb. 26, 1972
E. J. NORDBY, MD
Chairman

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

1972 ANNUAL MEETING

Scientific Program

IN CONDENSED FORM

State Medical Society of Wisconsin

MAY 9-11

MILWAUKEE

HOTEL SHERATON–SCHROEDER

DOWNTOWNER MOTOR INN and RAMADA INN

THE COMMISSION ON SCIENTIFIC MEDICINE is pleased to invite all physicians to attend the Scientific Program of the 1972 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 9 through 11. The Sheraton–Schroeder Hotel again will be the major location for the scientific program, although three roundtable luncheons will be held at the Downtowner Motor Inn and one at the Ramada Inn.

The Commission also wishes to note that the State Medical Society's Council and House of Delegates and related functions will be conducted May 6 through 10 at the Holiday Inn Central in Milwaukee. Details of these meetings appear elsewhere in this issue.

This year's scientific program includes the popular plenary sessions on the first two days, Tuesday and Wednesday—May 9 and 10, which all physicians are urged to attend. The sessions will carry out the theme of this year's program: "Infectious Disease—Action and Reaction—1972." Calvin M. Kunin, MD, Madison, Chief of Medicine, Veterans Administration Hospital; and Professor of Medicine, University of Wisconsin Medical School, is in charge of the plenary session on Tuesday while Michael W. Rytel, MD, Milwaukee, Associate Professor of Medicine; Medical College of Wisconsin; Chief, Section of Infectious Diseases, Medical College of Wisconsin, is in charge of the Wednesday plenary session.

Tuesday afternoon sessions will include the specialties of allergy, neurology, and pyschiatry as well as continuation of the plenary session. And Wednesday afternoon sessions will include the specialties of dermatology, plastic surgery, and public health as well as the plenary session.

Thursday's morning program includes a drug session, "Highlights of the Pharmacologic Essentials in Clinical Practice," followed by the resident–intern papers program. Also in the morning there will be wet clinics by the otolaryngologists and surgeons. Specialties having luncheons and afternoon sessions include anesthesia, orthopedics, ophthalmology, physical medicine and rehabilitation, otolaryngology, and surgery.

Scientific and technical exhibits will be located at the Sheraton–Schroeder Hotel.

There will be no Annual Dinner, but there will be a President's Reception at the Holiday Inn Central on Wednesday evening from 6:00 to 8:00 pm. Everyone is urged to attend.

A condensed version of the scientific program as scheduled on March 1 appears on the following pages along with other pertinent information on the business and related aspects of the Annual Meeting. Further program details also will appear in the April issue, and a complete program will be mailed to the membership in mid-April.

TIMETABLE

Annual Meeting: State Medical Society of Wisconsin
Milwaukee, Wisconsin: May 6–May 11, 1972

NOTE: S–S: Sheraton–Schroeder Hotel
H–I: Holiday Inn Central
D: Downtowner Motor Inn
R: Ramada Inn

SATURDAY, MAY 6

p.m.

5:30 Council Executive Committee Dinner (Coach N'Three) H–I
7:00 Council Executive Committee Meeting (Coach N'Three) H–I

SUNDAY, MAY 7

noon

12:00 Council Luncheon (Coach N'Three) H–I

p.m.

2:00 Council Meeting (Coach N'Three) H–I
2:00 Auxiliary Hospitality Room (Coach N'Four) H–I
4:00 Auxiliary Registration (off Lobby) H–I
6:00 Awards Dinner (Coach Light) H–I (50 Yr. Club; Councilors & Officers)

MONDAY, MAY 8

a.m.

8:00 Installation of exhibits (5th fl. & Empire Room, Lobby Fl.) S–S
8:00 Auxiliary Breakfast (Garden Terrace Rm.) H–I
8:00 Auxiliary Registration (off Lobby) H–I
9:00 Auxiliary Board Meeting (Garden Terrace Rm.) H–I
10:30 Section Delegates Caucus Meeting (Room 301) H–I
11:30 Auxiliary Luncheon (Garden Terrace Rm.) H–I

p.m.

1:00 House of Delegates Registration (Coach Light North) H–I
1:30 Auxiliary Business Meeting (Garden Terrace Rm.) H–I
2:00 House of Delegates, First Session (Coach Light Rm.) H–I
5:30 House of Delegates, Buffet Supper (Carriage Rm.) H–I
6:00 Auxiliary Dinner (Garden Terrace Rm.) H–I
7:30 REFERENCE COMMITTEES:
Resolutions & Amendments (Coach Light East Rm.) H–I
Reports of Standing Committees (Coach N'Three Rm.) H–I
Reports of Officers (Coach Light West Rm.) H–I
Finance (Warrior Rm.) H–I

TUESDAY, MAY 9

a.m.

7:30 PUBLIC AFFAIRS Breakfast (wives invited) (Garden Terrace Rm.) H–I
8:00 Auxiliary Registration (off Lobby) H–I
8:00 Registration (4th fl.) and opening of Exhibits (5th fl. & Empire Rm.–Lobby Fl.) S–S
8:30 Clinic Managers Meeting (Peletier Rm.) D
9:30 Auxiliary Business Meeting (Coach Light East Rm.) H–I
9:00 Scientific Programs:
Plenary Session: "Current Status of Venereal Disease" (Loraine Rm., Lobby Fl.) S–S

noon

12:00 Auxiliary Luncheon (Garden Terrace Rm.) H–I
12:00 Clinic Managers Luncheon (Tiffany Rm.) D

p.m.

12:15 Scientific Luncheons (4th, 5th fls.) S–S; R; D
2:00 Scientific Programs
Plenary Session (Loraine Rm, Lobby Fl.) S–S
Allergy: D

continued

TIMETABLE—*continued*

Pathology (English Rm., 5th fl.) S–S
Neurology (Pere–Marquette Rm., 5th fl.) S–S
Psychiatry (Parlor E, 4th fl.) S–S
2:00 Board of Directors, Wisconsin Academy of Family Physicians Meeting (Coach Light East Rm.) H–I
3:00 Nominating Committee (Warrior Rm.) H–I
6:00 House of Delegates Registration (Coach Light North) H–I
6:00 Radiology Dinner: Milwaukee Athletic Club
7:00 House of Delegates, Second Session (Coach Light Rm.) H–I

WEDNESDAY, MAY 10

a.m.

7:30 Catholic Physicians Guild Breakfast (Pere–Marquette Rm., 5th fl.) S–S
7:30 House of Delegates Registration (Coach Light North) H–I
8:30 Registration (4th fl.) and Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
8:30 Clinic Managers Meeting (Peletier Rm.) D
8:30 House of Delegates, Third Session (Coach Light Rm.) H–I
9:00 All day special Reference Committee meeting re: AMA Long-Range Planning (Room 504) S–S
9:00 Scientific Programs:
Plenary Session: "Infectious Disease Problems of Increasing Importance" (Loraine Rm., Lobby Fl.) S–S
10:30 Council Meeting (Coach N'Three Rm.) H–I
11:30 Board of Trustees, Charitable, Educational & Scientific Foundation Meeting (Coach N'Three Rm.) H–I

p.m.

12:15 Scientific Luncheons (4th & 5th fls.) S–S; D
12:30 Council and Board of Directors, CESF, Luncheon (Coach N'Four) H–I
2:00 Scientific Programs:
Plenary (Loraine Rm., Lobby Fl.) S–S
Dermatology (Pere–Marquette Rm., 5th fl.) S–S
Plastic Surgery (Clipper Rm.) D
Public Health (Parlor F, 4th fl.) S–S
6:00 President's Reception (Garden Terrace Rm.) H–I
6:00 Wisconsin Society of Plastic Surgery: Wisconsin Club
8:00 Marquette Alumni Dinner (Coach Light Rm.) H–I

THURSDAY, MAY 11

a.m.

8:30 Registration (4th fl.) and Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
9:00 Wet Clinc (Surgery) St. Joseph's Hospital, Milwaukee
10:00 Wet Clinic (Otolaryngology) V. A. Hospital, Wood
9:00 Scientific Programs
Drug Program (Loraine Rm., Lobby Fl.) S–S
10:30 Resident–Intern Papers Program (Loraine Rm., Lobby Fl.) S–S

noon

12:00 Past Presidents Luncheon (Coach N'Four Rm.) H–I

p.m.

12:15 Scientific Luncheons (5th fl.) S–S; D
2:00 Scientific Programs
Anesthesia (Clipper Rm.) D
Ophthalmology (Pere–Marquette Rm., 5th fl.) S–S
Orthopedics (Peletier Rm.) D
Otolaryngology (English Rm., 5th fl.) S–S
Physical Medicine & Rehabilitation (Parlor A, 4th fl.) S–S
Surgery (Loraine Rm., Lobby Fl.) S–S
3:45 Closing of Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
5:30 Wisconsin Orthopedic Society: Milwaukee Yacht Club
6:00 Milwaukee Ophthalmological Society: University Club
6:30 Wisconsin Surgical Society: Milwaukee Athletic Club

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

BYRON J. BAILEY, MD

Wiess Professor and Chairman, Department of Otolaryngology, University of Texas, Galveston, Tex.

THURSDAY, MAY 11: 2:20 pm—*Management of Maxillofacial Injuries*

RICHARD H. EGDAHL, MD

Professor and Chairman, Department of Surgery, Boston University Medical Center, Boston Mass.

THURSDAY, MAY 11: 2:30 pm—*Diagnosis and Treatment of Hyperparathyroidism*

LEE T. FORD, MD

Assistant Professor of Clinical Orthopaedic Surgery, Washington University, St. Louis, Mo.

THURSDAY, MAY 11: 2:00 pm—*Use of Chymopapain in Lumbar Disc Lesions;* 12:15 pm—*Examination of Patient with Low Back and Sciatic Pain*

J. K. FRENKEL, MD, PhD

Professor of Pathology, University of Kansas Medical Center, Kansas City, Kan.

WEDNESDAY MAY 10: 1:45 pm—*Topless Toxoplasma—Bottomless Problems of Toxoplasmosis*

HERBERT E. KAUFMAN, MD

Professor of Ophthalmology and Pharmacology; Chairman, Department of Ophthalmology, College of Medicine, University of Florida, Gainesville, Fla.

THURSDAY, MAY 11: 1:30 pm—*Current Concepts in Management of Herpetic Infections;* evening dinner speaker—*Medical and Surgical Treatment of Corneal Disease*

CHARLES H. KIRKPATRICK, MD

Head, Section of Allergy and Hypersensitivity, Laboratory of Clinical Investigation, NIH, Bethesda, Md.

TUESDAY, MAY 9: 3:30 pm—*Deficiency of Cell Mediated Immunity;* 12:15 pm—*Current Intramural Programs of the National Institutes of Allergy and Infectious Disease*

EDWARD LOWENSTEIN, MD

Anesthetist, Massachusetts General Hospital, Boston, Mass.

THURSDAY, MAY 11: 3:00 pm—*Anesthetic Considerations in Coronary Artery Disease;* 12:15 pm—*Autologous Blood Retransfusion Following Extracorporeal Bypass in the Cardiac Surgery Patient*

PETER J. LYNCH, MD

Associate Professor of Dermatology, University of Michigan School of Medicine, Ann Arbor, Mich.

WEDNESDAY, MAY 10: 3:00 pm—*Host—Microbial Interactions from a Dermatological Viewpoint;* 12:15 pm *Problems in Dermatologic Diagnosis and Therapy*

H. HOUSTON MERRITT, MD

Professor Emeritus of Neurology and Dean Emeritus, Faculty of Medicine, Columbia University College of Physicians and Surgeons, New York City

TUESDAY, MAY 9: 3:30 pm—*Neurosyphilis: A Review and a Look to the Future;* 12:15 pm—*Neurology—Past and Future*

ARNOLD L. SCHROETER, MD

Consultant, Department of Dermatology, Mayo Clinic, Rochester, Minn.

TUESDAY, MAY 9: 9:00 am—*Epidemiology and Treatment of Gonorrhea*

G. KEITH STILLWELL, MD

Associate Professor of Clinical Physical Medicine and Rehabilitation, Mayo Graduate School of Medicine, Rochester, Minn.

THURSDAY, MAY 11: 2:00 pm—*Role of Physical Medicine in Management of Osteoarthritis*

JOSEPH P. WHALEN, MD

Professor of Radiology, The New York Hospital—Cornell Medical Center, New York City

THURSDAY, MAY 11: Evening dinner speaker—*Radiographic Approach to Abdominal Masses;* 12:15 pm—*The Role of the Radiology Assistant*

HARVEY A. ZAREM, MD

Associate Professor of Surgery; Head, Section of Plastic Surgery, University of Chicago, Chicago, Ill.

WEDNESDAY, MAY 10: 1:15 pm—*Breast Reconstruction;* 3:00 pm—*Use of Pedicle Flaps for Reconstruction in Cancer Surgery of the Head and Neck*

SPECIAL REFERENCE COMMITTEE MEETING RE:

AMA Long-Range Planning

ALL DAY WEDNESDAY, MAY 10

All physicians are welcome to attend and express their views on proposed AMA constitutional convention by President Wesley Hall, MD. SMS Delegates to the AMA and representatives of the Long-Range Planning Committee of the AMA will be present to meet with physicians and solicit their opinions.

Special Annual Meeting Features!

TRADITIONAL CRAFTS AND FINE ARTS SHOW

Ceramics, Drawings and Graphic Arts, Paintings (acrylic, oil, watercolor), Photography, Sculpture, and Three Dimensional Design (crewel, needlepoint, macrame, metalwork, lapidary, pottery, weaving and textiles, woodwork).

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin

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PHOTOGRAPHY CONTEST

Beautiful and exciting pictures taken by physicians. Featuring medicine, travel, people, animals, and general pictorial scenes.

ON DISPLAY IN THE EAST ROOM, SHERATON–SCHROEDER HOTEL

TUESDAY, MAY 9

9:00 am to 12:00 noon—Scientific Program

PLENARY SESSION:

"Current Status of Venereal Disease"

EPIDEMIOLOGY AND TREATMENT OF GONORRHEA
Arnold L. Schroeter, MD, Rochester, Minn.
Consultant in Dermatology, Mayo Clinic

GONORRHEA IN THE FEMALE
Douglas O. Clark, MD, Milwaukee
Assistant Clinical Professor, Medical College of Wisconsin

GONOCOCCEMIA AND ARTHRITIS
Gerald J. Dorff, MD, Milwaukee
Clinical Instructor in Medicine, Department of Medicine, Section Infectious Diseases, Medical College of Wisconsin

DIAGNOSIS AND TREATMENT OF SYPHILIS
Walter E. Gager, MD, Milwaukee
Assistant Clinical Professor, Medical College of Wisconsin

PATHOLOGY OF CARDIOVASCULAR SYPHILIS
J. M. B. Bloodworth, Jr., MD, Madison
Professor of Pathology, University of Wisconsin Medical School, Chief, Laboratory Service, Veterans Administration Hospital

PATHOLOGY OF NEUROSYPHILIS
Alden W. Dudley, Jr., MD, Madison
Director, Neuropathology Training Program, University of Wisconsin Medical School

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

GERALD J. DERUS, MD _____Madison
Chairman

EINAR R. DANIELS, MD _____Wauwatosa
General Program Chairman

ROBERT G. WOCHOS, MD _____Green Bay
Scientific Exhibits

NORMAN O. BECKER, MD _____Fond du Lac
SIGURD E. SIVERTSON, MD _____Madison
EDWIN C. ALBRIGHT, MD _____Madison
EDWARD ZUPANC, MD _____Monroe
RICHARD C. BROWN, MD _____Eau Claire

Ex officio:

GERALD A. KERRIGAN, MD _____Milwaukee
Dean, Medical College of Wisconsin

HENRY C. PITOT, MD _____Madison
Acting Dean, University of Wisconsin Medical School

VICTOR S. FALK, MD _____Edgerton
Medical Editor: *The Wisconsin Medical Journal*

12:15 to 1:30 pm—Scientific Luncheons

1. PLENARY

VENERAL DISEASE
A. L. Schroeter, MD, Rochester, Minn.
Discussion Leader

NOSOCOMIAL ACQUIRED INFECTIONS
Calvin M. Kunin, MD, Madison
Discussion Leader

MENINGITIS AND ENCEPHALITIS
June Osborn, MD, Madison
Discussion Leader

PNEUMONIA
Edwin L. Overholt, MD, La Crosse
Discussion Leader

ANTIBIOTICS IN OFFICE PRACTICE
J. Donald Coonrod, MD, Milwaukee
Discussion Leader

2. ALLERGY

CURRENT INTRAMURAL PROGRAMS OF THE NATIONAL INSTITUTES OF ALLERGY AND INFECTIOUS DISEASE
Charles H. Kirkpatrick, MD, Bethesda, Md.
Head, Section of Allergy and Hypersensitivity, Laboratory of Clinical Investigation, NIH

3. NEUROLOGY

NEUROLOGY—PAST AND FUTURE
H. Houston Merritt, MD, New York City
Professor Emeritus of Neurology and Dean Emeritus, Faculty of Medicine, Columbia University College of Physicians and Surgeons

4. PATHOLOGY

TOPLESS TOXOPLASMA—BOTTOMLESS PROBLEMS OF TOXOPLASMOSIS
J. K. Frenkel, MD, PhD, Kansas City, Kan.
Professor of Pathology, University of Kansas Medical Center

5. PSYCHIATRY

PSYCHOTROPIC DRUGS, ANTIPSYCHOTIC TRANQUILIZERS
Rodney C. Johnson, MD, Sheboygan
Psychiatrist, Sheboygan Clinic

USE OF DRUGS FOR CHILDREN
James J. Balistrieri, MD, Milwaukee
Director, Juneau Academy

TRANQUILIZERS—USE AND ABUSE
David P. Donarski, MD, Green Bay
Psychiatrist

6. RADIOLOGY

ROLE OF THE RADIOLOGIST ASSISTANT
Joseph P. Whalen, MD, New York City
Professor of Radiology, The New York Hospital—Cornell Medical Center

Wisconsin Clinic Managers
CONVENTION
Tuesday, May 9–Wednesday, May 10
Downtowner Motor Inn
Luncheon—Tuesday, May 9

2:00 pm—Scientific Program

1. PLENARY SESSION:

Panel of Experts Discussing Cases of Infectious Disease, followed by case presentations

Edwin L. Overholt, MD, La Crosse
Arnold L. Schroeter, MD, Rochester, Minn.
Michael W. Rytel, MD, Milwaukee
June Osborn, MD, Madison
Discussants

William A. Craig, MD, Madison
J. Donald Coonrod, MD, Milwaukee
Thomas P. Monson, MD, Madison
Case Presentations

2. ALLERGY

ANTIBODY DEFICIENCY
Richard Hong, MD, Madison
Professor of Pediatrics, University of Wisconsin Medical School

DEFICIENCY OF CELL MEDIATED IMMUNITY
Charles H. Kirkpatrick, MD, Bethesda, Md.
Head, Section of Allergy & Hypersensitivity, Laboratory of Clinical Investigation, NIH

BUSINESS MEETING
Wisconsin Allergy Society

3. NEUROLOGY

PITFALLS IN THE DIAGNOSIS AND TREATMENT OF THE MENINGITIDIES IN CHILDREN
Stanley D. Johnsen, MD, Milwaukee
Assistant Professor of Pediatrics & Neurology, Medical College of Wisconsin

INFECTIOUS MONONUCLEOSIS ENCEPHALITIS
Timothy K. Henke, MD, La Crosse
Neurologist, Gundersen Clinic; Clinical Assistant Professor in Neurology, University of Wisconsin Medical School

INFECTIOUS MONONUCLEOSIS CEREBELLITIS
Henry A. Peters, MD, Madison
Professor of Neurology, University of Wisconsin Medical School
Paul L. Schraeder, MD, Madison
Resident, Department of Neurology, University of Wisconsin Medical School

NEUROSYPHILIS: A REVIEW AND A LOOK TO THE FUTURE
H. Houston Merritt, MD, New York City
Professor Emeritus of Neurology and Dean Emeritus, Faculty of Medicine, Columbia University College of Physicians and Surgeons

FAST AND SLOW GROWING VIRUSES: CLINICAL AND NEUROPATHOLOGICAL ASPECTS
June Osborn, MD, Madison
Associate Professor of Medical Microbiology and Pediatrics, University of Wisconsin Medical School
Gabriele M. Zu Rhein, MD, Madison
Professor of Pathology, University of Wisconsin Medical School

4. PSYCHIATRY

HOW TO KNOW YOURSELF
Keith M. Keane, MD, Appleton

IMPACT ON MEDICINE
William H. Heywood, MD, Marshfield

WEDNESDAY, MAY 10

9:00 am to 12:00 noon—Scientific Program

PLENARY SESSION:

"Infectious Disease Problems of Increasing Importance"

TUBERCULOSIS, PERSPECTIVES ON DIAGNOSIS AND TREATMENT
William W. Stead, MD, Milwaukee
Professor of Medicine, Medical College of Wisconsin

DISEASES OF THE COMPROMISED HOST, (NOCARDA, CYTOMEGALOVIRUS, PNEUMOCYSTIS, ETC.)
Michael W. Rytel, MD, Milwaukee

ASPERGILLOSIS
Charles E. Reed, MD, Madison
Professor of Medicine, University of Wisconsin Medical School

PSEUDOMONAS
Harold D. Rose, MD, Milwaukee
Assistant Professor of Medicine, Medical College of Wisconsin

DISEASE IN THE VIET NAM RETURNEE (MALARIA, MELLIDOSIS, AMEBIASIS, ETC.)
Edwin L. Overholt, MD, La Crosse

GEOGRAPHIC MEDICINE—ADVICE FOR THE PATIENT TRAVELING ABROAD (IMMUNIZATIONS, TROPICAL DIARRHEA, PARASITIC INFECTIONS)
André J. Lebrun, MD, DPH, DTM, Milwaukee
Milwaukee City Health Department; Associate Clinical Professor of Preventive Medicine, Medical College of Wisconsin

CURRENT STATUS OF VIRAL HEPATITIS
Duard L. Walker, MD, Madison
Professor and Chairman, Department of Medical Microbiology, University of Wisconsin Medical School

Catholic Physicians Guild

BREAKFAST

Wednesday, May 10—7:30 AM

Pere Marquette Room/Sheraton–Schroeder Hotel

12:15 to 1:30 pm—Scientific Luncheons

1. PLENARY

TUBERCULOSIS

William W. Stead, MD, Milwaukee
Discussion Leader

DISEASE OF THE COMPROMISED HOST

Michael W. Rytel, MD, Milwaukee
Discussion Leader

HOW THE LABORATORY CAN HELP MAKE THE DIAGNOSIS

Duard L. Walker, MD, Madison
Discussion Leader

INFECTIOUS DISEASE AS A WORLD HEALTH PROBLEM

Edwin L. Overholt, MD, La Crosse
Discussion Leader

IS IT ASTHMA OR INFECTIOUS BRONCHIOLITIS?

Hugh L. Moffet, MD, Madison
Discussion Leader

2. DERMATOLOGY

PROBLEMS IN DERMATOLOGIC DIAGNOSIS AND THERAPY

Peter J. Lynch, MD, Ann Arbor, Mich.
Associate Professor of Dermatology, University of Michigan School of Medicine

3. PLASTIC SURGERY

BREAST RECONSTRUCTION

Harvey A. Zarem, MD, Chicago
Associate Professor Surgery; Head, Section of Plastic Surgery, University of Chicago

4. PUBLIC HEALTH

THE HEALTH MAINTENANCE ORGANIZATION

Gerald J. Derus, MD, Madison
Assistant Clinical Professor of Pediatrics, University of Wisconsin Medical School

5. SURGERY

WISCONSIN COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS

Co-sponsored by Wisconsin Chapter, American College of Surgeons

NOON SCIENTIFIC LUNCHEONS

Make reservations early!

See reservation form on page 26

2:00 pm—Scientific Program

1. PLENARY SESSION

RESPIRATORY VIRUSES

Hugh L. Moffet, MD, Madison
Madison General Hospital

MYCOPLASMA PNEUMONIA

Donn J. D'Alessio, MD, Madison
Assistant Professor of Preventive Medicine and Medicine, University of Wisconsin Medical School

BACTERIAL PNEUMONIAS

J. Donald Coonrod, MD, Milwaukee
Assistant Professor of Medicine, Medical College of Wisconsin

RADIOLOGY OF PNEUMONIAS

Gerard T. Scanlon, MD, Milwaukee
Professor of Radiology, Medical College of Wisconsin

2. DERMATOLOGY

RECOGNITION AND TREATMENT OF SUPERFICIAL FUNGOUS INFECTIONS OF SKIN

Sharon D. Lantis, MD, Madison
Clinical Instructor in Dermatology, University of Wisconsin Medical School

RECOGNITION AND TREATMENT OF CUTANEOUS MONILIASIS

Hubert V. Moss, MD, Madison
Jackson Clinic

RECOGNITION AND MANAGEMENT OF VIRAL INFECTIONS OF SKIN

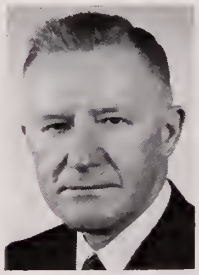
Stephen B. Webster, MD, La Crosse
Dermatology Department, Gundersen Clinic, Ltd.

RECOGNITION AND MANAGEMENT OF BACTERIAL INFECTIONS OF SKIN

Thomas J. Russell, MD, Milwaukee
Assistant Clinical Professor of Dermatology, Medical College of Wisconsin

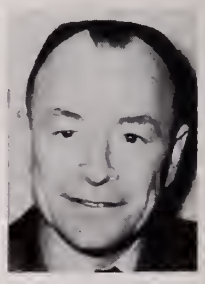
HOST–MICROBIAL INTERACTIONS FROM A DERMATOLOGICAL VIEWPOINT

Peter J. Lynch, MD, Ann Arbor, Mich.
Associate Professor of Dermatology, University of Michigan School of Medicine



E. R. Daniels, MD
Chairman, General Program

R. G. Wachas, MD
Chairman, Scientific Exhibits



G. J. Derus, MD
Chairman, Commission on Scientific Medicine

3. PLASTIC SURGERY

MINIMAL BREAST CANCER

Jerome J. DeCosse, PhD, MD, Milwaukee
Professor and Chairman, Division of Surgery, Medical College of Wisconsin

AVULSING INJURIES OF THE NOSE

Sidney K. Wynn, MD, Milwaukee
Clinical Professor of Plastic Surgery, Medical College of Wisconsin

THE EVALUATION AND MANAGEMENT OF VELO-PHARYNGEAL INCOMPETENCE

John E. Hamacher, MD, Madison
Clinical Assistant Professor of Surgery, University of Wisconsin Medical School

IMMEDIATE AND LATE TREATMENT OF CENTRAL FACIAL FRACTURES

Paul Natvig, MD, Milwaukee
Associate Clinical Professor of Plastic and Reconstructive Surgery, Medical College of Wisconsin

CURRENT TRENDS IN FLEXOR TENDON REPAIR

William H. Frackelton, MD, Milwaukee
Clinical Professor, Department of Plastic Surgery, Medical College of Wisconsin

USE OF PEDICLE FLAPS FOR RECONSTRUCTION IN CANCER SURGERY OF THE HEAD AND NECK

Harvey A. Zarem, MD, Chicago
Associate Professor of Surgery; Head, Section of Plastic Surgery, University of Chicago

BUSINESS MEETING

Wisconsin Society of Plastic Surgeons

4. PUBLIC HEALTH

A TWO-HOUR PROGRAM

Followed by a business and education meeting of the Wisconsin Association of Public Health Physicians

SPECIAL PROGRAM

Presentation of

RESIDENT–INTERN PAPERS

THURSDAY, MAY 10 (10:30–12:00 N)

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the other as the HARRY BECKMAN AWARD

Chairman: *Gerald J. Derus, MD,* Madison
Chairman of the Commission on Scientific Medicine

Presentations will be limited to approximately ten minutes each

JUDGES: Edwin C. Albright, MD, Madison, Chairman; Anthony V. Pisciotta, MD, Milwaukee; and Richard I. H. Wang, PhD, MD, Milwaukee

THURSDAY, MAY 11

9:00 am to 12:00 noon—Scientific Program

1. DRUG PROGRAM:

"Highlights of the Pharmacologic Essentials in Clinical Practice"

G.I. DRUGS—EFFECTIVE AND SOME NOT SO EFFECTIVE

George E. Whalen, MD, Milwaukee
Associate Professor of Medicine, Medical College of Wisconsin

STEROIDS

Paul S. Rosenfeld, MD, Milwaukee
Chief, Endocrine–Metabolic Section, VA Center—Wood; Assistant Professor of Medicine, Medical College of Wisconsin

DRUG COMBINATIONS IN HYPERTENSION

Theodore L. Goodfriend, MD, Madison
Associate Professor of Internal Medicine & Pharmacology, University of Wisconsin Medical School

DRUG INTERACTION

Richard I. H. Wang, PhD, MD, Milwaukee
Chief, Clinical Pharmacology Service, Veterans Administration Hospital; Professor of Clinical Pharmacology, Medical College of Wisconsin

2. RESIDENT–INTERN PAPERS PROGRAM

(See box elsewhere in this issue)

3. OTOLARYNGOLOGY

Wet Clinic

4. SURGERY

Wet Clinic

HODGKIN'S DISEASE

James M. Kenney, MD

HYPERALIMENTATION

William B. Kelley, MD

CARCINOMA OF THE BREAST—EXPERIENCE AT ST. JOSEPH'S HOSPITAL

A. Thiru, MD

ZOLLINGER–ELLISON SYNDROME

Sadao Kasai, MD

HYPERPARATHYROIDISM

John C. Bishop, MD

THYROIDITIS

Robert A. Haushalter, MD

VASCULAR INJURIES ATTENDANT TO ARTERIAL CATHETERIZATION

Robert J. Beckes, MD

12:15 to 1:30 pm—Scientific Luncheons

1. ANESTHESIA

AUTOLOGOUS BLOOD RETRANSFUSION FOLLOWING EXTRACORPOREAL BYPASS IN THE CARDIAC SURGERY PATIENT

Edward Lowenstein, MD, Boston, Mass.
Anesthetist, Massachusetts General Hospital

2. OTOLARYNGOLOGY

BUSINESS MEETING
No speaker

3. ORTHOPEDICS

EXAMINATION OF THE PATIENT WITH LOW BACK AND SCIATIC PAIN

Lee T. Ford, MD, St. Louis, Mo.
Assistant Professor of Clinical Orthopaedic Surgery, Washington University

2:00 pm—Scientific Program

1. ANESTHESIA

MANAGEMENT OF THE PATIENT WITH SEVERE HEAD INJURY

S. Craighead Alexander, MD, Madison
Professor and Chairman, Department of Anesthesia, University of Wisconsin Medical School

ANESTHETIC CONSIDERATIONS IN CORONARY ARTERY DISEASE

Edward Lowenstein, MD, Boston, Mass.
Anesthetist, Massachusetts General Hospital

CARDIAC TRANSPLANTATION

Donald R. Kahn, MD, Madison
Professor of Surgery, University of Wisconsin Medical School

2. OPHTHALMOLOGY

CURRENT CONCEPTS IN MANAGEMENT OF HERPETIC INFECTIONS

Herbert E. Kaufman, MD, Gainesville, Fla.
Professor of Ophthalmology & Pharmacology; Chairman, Department of Ophthalmology, College of Medicine, University of Florida

PANEL

CLINICO-HISTOPATHOLOGIC CORRELATION

Harry A. Easom, MD, Milwaukee
Associate Clinical Professor of Ophthalmology, Medical College of Wisconsin

Guillermo de Venecia, MD, Madison
Associate Professor of Ophthalmology, University of Wisconsin Medical School

3. ORTHOPEDICS

USE OF CHYMOPAPAIN IN LUMBAR DISC LESIONS

Lee T. Ford, MD, St. Louis, Mo.
Assistant Professor of Clinical Orthopaedic Surgery, Washington University

ULNAR NERVE LESIONS

Donald R. Gore, MD, Sheboygan
Clinical Instructor, Department of Orthopedics, Medical College of Wisconsin

OSTEOGENESIS IMPERFECTA AND ADRENOGENITAL SYNDROME (Case Presentation)

Henry I. Okagaki, MD, Madison
Associate Professor of Surgery, University of Wisconsin Medical School

Peter B. Salamon, MD, Madison
Resident in Surgery, University of Wisconsin Medical School

SKELETAL EFFECTS OF RHEUMATOID ARTHRITIS

John M. Jurist, PhD, Madison
Assistant Professor of Orthopedic Surgery, University of Wisconsin Medical School

DECOMPRESSION EFFECTS ON ARTICULAR CARTILAGE FOLLOWING HIP OSTEOTOMY

Karl H. Mueller, MD, Milwaukee
Associate Clinical Professor of Orthopedic Surgery, Medical College of Wisconsin

4. OTOLARYNGOLOGY

THE RADICAL NECK DISSECTION IN LARYNGEAL CARCINOMA

Mark L. Satz, MD, Madison
Senior Resident in Otolaryngology, University of Wisconsin Medical School

CARCINOMA OF PALATINE ARCH

Alexander Locke, Jr., MD, Milwaukee
Senior Resident in Otolaryngology, Veterans Administration Hospital

MANAGEMENT OF MAXILLOFACIAL INJURIES

Byron J. Bailey, MD, Galveston, Tex.
Wiess Professor and Chairman, Department of Otolaryngology, University of Texas

5. PHYSICAL MEDICINE & REHABILITATION

ROLE OF PHYSICAL MEDICINE IN MANAGEMENT OF OSTEOARTHRITIS

G. Keith Stillwell, MD, Rochester, Minn.
Associate Professor of Clinical Physical Medicine and Rehabilitation, Mayo Graduate School of Medicine

RELATIONSHIP OF THE INDIVIDUAL SPECIALTY TO THE GENERAL TOPIC

Robert C. Zuege, MD, Milwaukee
"Surgical Solutions in Treatment of Osteoarthritis"

Gerson C. Bernhard, MD, Milwaukee
"Rheumatology Considerations"

Edwin C. Welsh, MD, Milwaukee
"Summation"

6. SURGERY

SECOND LOOK OPERATIONS IN COLON CARCINOMA FOLLOWING ADJUNCTIVE 5-FLUOROURACIL THERAPY
Sanford Mackman, MD, Madison
Associate Clinical Professor of Surgery, University of Wisconsin Medical School

EXPERIENCE WITH THE Z–E TUMOR REGISTRY
Stuart D. Wilson, MD, Milwaukee

AMPUTATION—EXPERIENCE WITH IMMEDIATE POST SURGICAL FITTING
Alfred E. Kritter, MD, Waukesha
Orthopedic Surgeon

DIAGNOSIS AND TREATMENT OF HYPERPARATHYROIDISM
Richard H. Egdahl, MD, Boston, Mass.
Professor and Chairman, Department of Surgery, Boston University Medical Center

CARDIAC PACEMAKERS—CLINICAL PROBLEMS AND MANAGEMENT
George M. Kroncke, MD, FACS, Madison
Assistant Professor, Division of Thoracic and Cardiovascular Surgery, University of Wisconsin Medical School

EXPERIENCE WITH CORONARY ARTERY SURGERY AT MARSHFIELD
William O. Myers, MD, Marshfield
Surgeon, Marshfield Clinic

SELECTION OF PATIENTS FOR CORONARY REVASCULARIZATION
W. Dudley Johnson, MD, Milwaukee
Associate Clinical Professor of Surgery, Medical College of Wisconsin; Chief of Cardiovascular Surgery, St. Luke's Hospital; Attending Surgeon, Milwaukee County General Hospital, Wood VA Hospital, and Milwaukee Children's Hospital

PANEL DISCUSSION: REWIRE, RETREAD, OR REPLACE?
Derward Lepley, Jr., MD, Milwaukee
Chairman, Department of Thoracic–Cardiovascular Surgery, Medical College of Wisconsin

PANEL:
W. Dudley Johnson, MD, Milwaukee
George M. Kroncke, MD, Madison
William O. Myers, MD, Marshfield
Donald R. Kahn, MD, Madison
Harold W. Harding, MD, Appleton
Francis F. Rosenbaum, MD, Milwaukee

PRESIDENT'S ADDRESS
Wayne J. Boulanger, MD, Milwaukee
Assistant Clinical Professor of Surgery, Medical College of Wisconsin

PUBLIC AFFAIRS Breakfast

Tuesday, May 9—7:30 AM

Garden Terrace Room/Holiday Inn Central
(wives included)

(NO Annual Dinner)

PRESIDENT'S RECEPTION

Wednesday, May 10

6 to 8 PM

Garden Terrace Room/Holiday Inn Central

Everyone attending the Annual Meeting is invited to join President George A. Behnke in welcoming the new President, Dr. Robert F. Purtell, and his wife, at an informal reception.

FRUIT PUNCH HORS D'OEUVRES

Steve Swedish Music

STATE MEDICAL SOCIETY OF WISCONSIN

Business Schedule

NOTE: *All business meetings* including House of Delegates, Reference Committees, Council, Council Committees, and related functions will be held at the *Holiday Inn Central* in Milwaukee

SATURDAY, MAY 6

Executive Committee of the Council
Dinner and Meeting

SUNDAY, MAY 7

Council Luncheon and Meeting
Awards Dinner—50 Year Club and others
Councilors and Officers

MONDAY, MAY 8

Section Delegates Caucus Meeting
First Session of the House of Delegates
Reports of officers, commissions, and committees, and new business
House of Delegates Buffet Supper
Reference Committees

TUESDAY, MAY 9

Nominating Committee
Second Session of the House of Delegates
Reports of Reference Committees

WEDNESDAY, MAY 10

Third Session of the House of Delegates
Election of officers
Council Meeting
Charitable, Educational and Scientific Foundation Board of Trustees Meeting
Council and CESF Board of Trustees Luncheon
President's Reception

See the TIMETABLE for details on time and room locations

RESERVATION FORMS FOR

Noon Scientific Luncheons

NOTE: Attendance Limited! Please list 2 choices for each of the days you make reservations. List in order of preference. $5.00 per luncheon, including gratuities and taxes.

TUESDAY, MAY 9

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. PLENARY: (a) Venereal Disease; (b) Nosocomial Acquired Infections; (c) Meningitis and Encephalitis; (d) Pneumonia; (e) Antibiotics in Office Practice
2. ALLERGY: Current Intramural Programs of the National Institutes of Allergy and Infectious Disease—Charles H. Kirkpatrick, MD, Bethesda
3. NEUROLOGY: Neurology: Past and Future—H. Houston Merritt, MD, New York City
4. PATHOLOGY: Topless Toxoplasma; Bottomless Problems of Toxoplasmosis—J. K. Frenkel, MD, PhD, Kansas City
5. PSYCHIATRY: (a) Psychotropic Drugs, Antipsychotic Tranquilizers—Rodney C. Johnson, MD, Sheboygan; (b) Use of Drugs for Children—James J. Balistrieri, MD, Milwaukee; (c) Tranquilizers: Use and Abuse—David P. Donarski, MD, Green Bay
6. RADIOLOGY: Role of the Radiologist Assistant—Joseph P. Whalen, MD, New York City

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 10

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. PLENARY: (a) Tuberculosis; (b) Disease of the Compromised Host; (c) How the Laboratory Can Help Make the Diagnosis; (d) Infectious Disease As a World Health Problem; (e) Is It Asthma or Infectious Bronchiolitis?
2. DERMATOLOGY: Problems in Dermatologic Diagnosis and Therapy—Peter J. Lynch, MD, Ann Arbor
3. PLASTIC SURGERY: Breast Reconstruction—Harvey A. Zarem, MD, Chicago
4. PUBLIC HEALTH: The Health Maintenance Organization—Gerald J. Derus, MD, Madison
5. SURGERY: Wisconsin Committee on Trauma, American College of Surgeons

First Choice: _____ Second Choice: _____

THURSDAY, MAY 11

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ANESTHESIA: Autologous Blood Retransfusion Following Extracorporeal Bypass in the Cardiac Surgery Patient—Edward Lowenstein, MD, Boston
2. OTOLARYNGOLOGY: No speaker. Business meeting to follow luncheon
3. ORTHOPEDICS: Examination of the Patient with Low Back and Sciatic Pain—Lee T. Ford, MD, St. Louis

First Choice: _____ Second Choice: _____

Number Luncheon Tickets ($5.00 each) . . . _____ for $ _____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ **STREET** _____ **CITY** _____

(Print, please)

MAIL TO: State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701

fotos/72

STATE MEDICAL SOCIETY PHOTOGRAPHY CONTEST

OPEN TO ALL MEMBERS OF THE STATE MEDICAL SOCIETY

Contest rules have been simplified to make it easier to enter your photographs.

All photographs entered should be mounted in the form in which entrant would like his prints to be exhibited. Mounted pieces should not exceed 16 inches by 20 inches. No frames will be accepted.

Prize winning photographs, if received unmounted, will be mounted on 16 x 20 boards for display at the State Medical Society Annual Meeting.

CLASSIFICATIONS

Medicine, Travel, People (at play and at work), Animals, Pictorial (landscape, objects, still life, etc.).

ENTRIES

A maximum of 10 prints may be entered by each entrant. All entries must be at the State Medical Society headquarters in Madison by April 24, 1972.

Entries must carry the following information on the back of the photo or mounting board: Title, class entered, name and address of exhibitor. There shall be no writing or printing on the front of the mounting board or any photo. All photos entered must be taken by the entrant but developing, enlarging and mounting need not be done by him.

AWARDS

Each division, black and white or color, will be judged separately and the following awards given to each classification: First place, second place and third place. In addition, three honorable mention awards will be given to each classification. There will be an award of "Best In Show" given to the best entry, either black and white or color. Trophies will be given to all first place winners and to the "Best In Show" and ribbons for all other awards.

JUDGING

Judging will take place prior to the showing of entries at the Annual Meeting. Winners will be notified of their awards as soon after judging as possible.

★

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WISCONSIN MEDICAL JOURNAL
Vol. 71, No. 3 MARCH 1972

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

RESOLUTION DEADLINE IS APRIL 10

Resolutions for consideration by the State Medical Society's House of Delegates must be filed by April 10 in order to be taken up at the annual session May 8, 9, and 10.

The April 10 deadline is set by the Society's Bylaws, which calls for the filing of resolutions with the Secretary no later than 30 days prior to the first session of the House of Delegates. The Secretary's office is available for assistance in preparation of fiscal notes, which should accompany resolutions calling for expenditures from the State Medical Society's budget.

April 4 Referendum Set for Medical Examiner Amendment

The final step is at hand in the long-fought battle to permit any county or group of counties to have medical examiners rather than coroners.

Physicians are urged to vote "yes" on the proposed amendment to the Wisconsin Constitution which will be presented to the voters as a referendum on the April 4 primary ballot. Because the office of coroner is a constitutional one in Wisconsin, an amendment is necessary and the referendum is the last step in the amending procedure.

In February both houses of the Legislature passed the amendment. This was the second consecutive session in which both Senate and Assembly had passed it. All constitutional amendments must go through this double consideration.

The Constitution has already been amended to allow a county of over 500,000 population to adopt a medical examiner system instead of electing a coroner. Only Milwaukee County falls into that category and has had a medical examiner since the previous constitutional amendment took effect.

To make the office of coroner optional for all counties, a bill to further amend the Constitution was introduced in the 1967 Legislature at the request of the House of Delegates of the State Medical Society. It did not pass both houses that session and was reintroduced during the 1969 session. Although the bill had some determined opponents, both houses OK'd the measure. This time there was little opposition to passage.

Since the bill was first introduced, many Wisconsin civic groups and newspapers have given it strong support. It has been pointed out repeatedly that the law specifying the coroner's duties does not specify any qualifications for the person holding that office. Any layman may run for the two-year term provided in the state Constitution. Usually,

continued on page 34

Council Okays AMA Open Hearings at Annual Meeting in Milwaukee

Wisconsin physicians will be the first in the nation to have an opportunity in open forum to air their feelings about the future course of the American Medical Association.

Representatives of the AMA's Council on Long-Range Planning and Development will hold open hearings all day Wednesday, May 10, at Milwaukee's Sheraton–Schroeder Hotel as part of the State Medical Society's Annual Meeting. The hearings will commence at 9 a.m. in Room 504, continue until noon, and reconvene at 1:30 p.m. until 4:30 p.m.

The State Medical Society will mail a notice at the end of this month to all Society members giving full particulars. This will be followed by a special communication to medical societies from the AMA itself.

The Long-Range Planning Council has been directed by the AMA House of Delegates to hold hearings at the 1972 annual convention in June in San Francisco and again at the Clinical Session next November. The Wisconsin

continued on page 35

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1972 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

candidates are not physicians and have had no particular training for the job. So the coroner has to turn to other experts to get everything from fingerprints to autopsies.

The system gives him criminal and medical authority over these experts. If a physician called into a case decides an autopsy should be done—for example, because the symptoms indicate poison—the coroner can disagree and not order an autopsy. The physician's only recourse in such a case is to notify the district attorney. A few counties have circumvented the problem by persuading physicians to run for the office of coroner.

When Wisconsin changes its Constitution to allow medical examiners, it will join the majority of states in the nation which no longer have the coroner system. The Society believes it is most important that all physicians actively make others aware of the necessity to vote in favor of the referendum in April. Newspaper editors should be encouraged to print favorable editorials on the subject. Reprinted below are samples of editorials that have appeared in the past when the amendment was before the Legislature.

A Pathologist for Coroner!

What a surprise! In Kenosha County, a pathologist, an expert in the causes of death, is running for the office of coroner, the official whose job it is to certify the causes of death under unusual circumstances.

Usually, candidates for coroner are former store owners, or factory workers, or teachers, or almost anyone who has had no particular training for serving in this capacity. They are intelligent enough individuals, but often have absolutely no previous experience which would prepare them for the job. One notable exception in this area is in Lincoln County, where a Merrill physician holds the office.

The office requires extensive medical knowledge as well as knowledge of criminal investigation and judicial proceedings, so it isn't easy to find someone fully qualified in each county. But as long as we continue the ridiculous procedure of electing the coroner, we will probably continue to have coroners who have no qualifications.

It is time Wisconsin changes its elective procedure for coroners and sets up statutes providing for appointment of better qualified individuals.

WAUSAU RECORD-HERALD, June 6, 1968

Why a Coroner? Asks Coroner, in Effect

County Coroner Ted Witheril wrote the best obituary for his own office we have read:

"In this age of modern science, it is incredible to think of a coroner making unnecessary guesses on death certificates."

In this day and age, it is incredible to think of a coroner, period.

* * *

Witheril, in asking that the County Board treble his funds for pathologists' fees for post-mortem examinations, is saying what is self-evident: a lay coroner cannot actually determine the cause of death; he can only ask a qualified physician. And, if the doctor must supply the answer anyhow, why a coroner?

But our law requires the coroner to go through the ancient folderol of making a determination of the cause of death, or convening a jury of six laymen who know nothing more about medicine than he does, and going through the motions of taking testimony and solemnly confirming the findings of a medical expert who could have given the answer as soon as he made the necessary examination and tests.

* * *

None of this makes any sense, and it costs money—not much money, but more than should be spent unnecessarily.

In the process of modernizing county government, the office of coroner and its ancient trapping should be eliminated. If the county is going to be required to pay for post-mortem examinations of all or most deaths unattended by a physician, it can skip the middleman.

RACINE JOURNAL, April 12, 1967

SERVING AS AMA delegates at the AMA Clinical Session in New Orleans last fall were the following MDs: E. M. Dessloch, Prairie du Chien, alternate delegate; G. E. Collentine, Jr., Milwaukee, delegate; C. J. Picard, Superior, delegate; W. T. Russell, Sun Prairie, alternate delegate; J. M. Bell, Marinette, delegate; and R. E. Galasinski, Milwaukee, delegate. The Wisconsin delegation introduced the resolution, which the AMA House passed, calling for open hearings to discuss innovative changes in the organizational structure of the AMA. The first open hearings will be held in Wisconsin during the State Medical Society's Annual Meeting in Milwaukee. The all-day affair will be held on Wednesday, May 10, at the Sheraton–Schroeder Hotel. All physicians are urged to attend and voice their opinions.

AMA Open Hearings at Annual Meeting All Day May 10

continued

hearings will be the first in a series of regional hearings which have also been scheduled.

The hearings are being held to find ways the AMA can become more responsive to its members and the public. They were proposed by Wisconsin's AMA delegation at the last Clinical Convention November 28–December 1 in New Orleans.

The State Medical Society's Council endorsed the hearings at its February 26 meeting. Other Council actions at that meeting included:

- Approval of a resolution endorsing a National Institutes of Health study of nursing practice in a seven-state, upper midwest region. One aim of the study is to remove barriers which prevent easy transfer of health professionals from state to state. The survey includes Iowa, Michigan, Minnesota, Montana, North Dakota, South Dakota, and Wisconsin.
- Recommendation that general tax funds be used for regional perinatal centers. This is an alternate to the obstetrical bed tax proposed in Bill 597, S. in the recently completed legislative session.
- Establishment of a Society award to the "Citizen Physician" of the year.
- Received a report from the Committee on Planning which is reviewing the Society's Bylaws. Further information will be presented to the Council in May during the Annual Meeting.
- Adoption of the Society's 1972 budget with anticipated income of $657,300 and expenditures of $642,300. This must receive final approval from the House of Delegates when it meets in May.
- Recommendation that the state's residency training and nursing education programs be financed by all citizens, relieving the burden from hospital patients.
- Commendation of H. J. Kief, MD, Fond du Lac, for his service to the Professional Association for Civic Education (PACE). Dr. Kief recently retired as PACE chairman.

Public Affairs Breakfast to Feature Rep. Byrnes at SMS Annual Meeting

U. S. Representative John W. Byrnes, long-time Congressman from Wisconsin's 8th District, will speak to physicians and their wives May 9 at the public affairs breakfast during the State Medical Society's Annual Meeting in Milwaukee.

Representative Byrnes, who is serving his 14th consecutive term in office, is the senior Republican on the powerful House Ways and Means Committee, of which he has been a member for the past 12 years. He has served in state and national government for over 30 years. During that time he has consistently supported the independence of American medicine and the use of voluntary health insurance as the best method of health-care financing.

In January Rep. Byrnes announced that he would not seek reelection next November. He has cited the workload of his committee as one reason for his decision. The committee has been described as the "salt mine of the Congress" and its workload in recent years has been the heaviest on Capitol Hill.

Rep. John W. Byrnes

Tickets for the breakfast are $6.00 per person and may be ordered from the State Medical Society, Box 1109, Madison, WI 53701.

Other special events during the Society's Annual Meeting are listed in the condensed program which appears in this issue starting on page 17.

Health Policy Changes, Chiropractic Are Topics of Health Task Force

Changes in five areas of Wisconsin's health policy have been asked by the Governor's Health Planning and Policy Task Force.

At its February 25 meeting, the Task Force adopted the following resolutions which will be part of its interim report scheduled for completion in April:

- Minimum standards should be established for health insurance sold to Wisconsin residents to provide coverage that meets basic service needs.
- New state legislation defining the mandate and relationship of health planning agencies at the state and regional level should be developed.
- Priority for public funds for the mentally ill and the behaviorally disabled should be redirected from support of primarily long-term, residential institutions to community-based short-term and ambulatory services.
- Actions should be taken at this time to increase the supply of physicians' services in the state. Specifically, this resolution:

—supports increasing physician recruitment and retention through the development and improvement of residency programs in the state.

—supports promoting better retention of physicians by the state through the development and improvement of continuing education programs,

—supports the expansion of class size of the state's two medical schools, with a class size of 160 as a reasonable goal for each.

- Policy and planning for the mentally retarded and the developmentally disabled should be considered a matter which requires policy on the full range of necessary and appropriate services, including health.

At the same meeting the Task Force issued a policy statement which will guide the rest of its activities. Its basic premise is that it is a proper concern of public policy that health services be equitably available to all. It implies the use of public funds, laws, regulations and leadership to assure acceptable service to all persons. This would be done through substantially more analysis of people's needs and some changes in approaches to the delivery of health care.

In other action, the Task Force set up a four-member chiropractic study work group, headed by Attorney Gilda B. Shellow, Milwaukee. Other members are: Professor William Blockstein, chairman of the University of Wisconsin Extension Health Services Unit, Robert Durkin, vice-president of the Milwaukee County Labor Council, AFL–CIO; and Professor Wendell Hunt, University of Wisconsin—Milwaukee Department of Curriculum and Instruction.

The State Medical Society's Commission on Public Policy has established an ad hoc committee on chiropractic which will offer information to the Task Force committee as well as study what actions the Society should take in this area. This was approved by the Council at its February 26 meeting.

At the same Council meeting, Task Force member Robert E. McMahon, MD, La Crosse, explained a questionnaire which was sent to all State Medical Society councilors. He said the Personal Health Services Work Group of the Task Force, of which he is a member, needs information about medical care conditions in various parts of the state. He encouraged all interested physicians to give their opinions about priorities for action within counties or regions. He said he would report back to the Council when the results of the questionnaire have been compiled.

Iowa County Seeks Information to Aid in Identification

Iowa County authorities are asking physicians in Wisconsin and surrounding states for help in identifying two bodies recently found in the county under mysterious circumstances.

Both bodies had gunshot wounds and were partially burned, making identification difficult. However, one of the bodies had unusual markings which might be recalled by an attending physician.

Their description follows: White male (age 19 to 30), about 6 feet tall and weighing 160 lb, with light blond hair. Poor eyesight, wore contact lenses. Has a 14-cm upper abdominal midline scar with blueish suture marks. BILATERAL CLAW FEET—"lobster claw type."

The other body is that of a young white male, with medium brown hair, brown eyes, weight approximately 140 lb, height approximately 5'4". Probable date of death Jan. 22, 1972.

Physicians having information that might help establish the identity of these young men are asked to write or call W. D. Hamlin, MD, Iowa County Coroner, Mineral Point, Wis. 53565, tel. 608/987–3212; or Sheriff Whitford, Dodgeville, Wis., tel. 608/935–3314.

Dr. Natoli Named to CMCP Post

Cornelius A. Natoli, MD, La Crosse, has been appointed to the State Medical Society's Commission on Medical Care Plans.

Dr. Natoli

The Commission directs Wisconsin Physicians Service (WPS Blue Shield) as well as other health care programs. This includes Medicare, Medicaid, and CHAMPUS for most of Wisconsin.

Dr. Natoli, a urologist, came to La Crosse in 1969 from Salt Lake City, Utah, where he had been in private practice for eight years. In 1965 he was certified by the American Board of Urology and is also a Fellow of the American College of Surgeons. He is on the staff of the Gundersen Clinic.

Stovall Memorial Plaque Dedication Apr. 29 at Museum

The 12th season for the Museum of Medical Progress in Prairie du Chien will begin April 15 followed by a dedication of a memorial plaque to William D. Stovall, MD, the man to whom the Museum owes its existence, on April 29.

When Dr. Stovall died last November he was president-emeritus of the State Medical Society's Charitable, Educational and Scientific Foundation which established the Museum and operates it.

Exhibits ranging from old time home remedies to the modern use of atomic energy are in place for the season. Through the use of lights, sound and action, they present the story of the human body in sickness and in health as well as a historic look at Wisconsin's frontier days.

Located at the site of historic Fort Crawford on the Mississippi River, the Museum is a national registered landmark.

The Fort dates back to 1826 and military displays from days of the Northwest Territory are side by side with examples of frontier medical instruments and Indian medicine.

On June 25 artists, sculptors, and craftsmen will be exhibiting and selling their work at the Third Annual Old Fort Crawford Art Fair. Artists interested in taking part should contact the Society offices in Madison, Box 1109, before June 1.

Other events at the Museum this summer will include the dedication of an 1818 "walking stick" cannon which will be added to the Museum grounds in July and the celebration of Heritage Day in September.

Museum hours are 8 a.m. to 5 p.m. daily April 15 through October 31.

Osteopath Is SMS Member

Henry O. Wick, Jr., DO, is the first osteopathic member of the State Medical Society. Dr. Wick is a resident in physical medicine and rehabilitation in a Medical College of Wisconsin affiliated program at the Veterans Administration Hospital, Wood.

The Society's bylaws were amended in 1970 to permit doctors of osteopathy to become members.

SMS committees *in action*

Use of Title "Doctor." Commission on Public Policy, February 23, authorized the State Medical Society to send a letter to the Attorney General and to the Director of the Department of Regulation and Licensing protesting the use of the title "Dr" in chiropractic Workmen's Compensation panels. This action was taken in response to a request of The Medical Society of Milwaukee County's Board of Directors.

Anti-Quackery Law. Commission on Public Policy, February 23, recommended to the Council that the State Medical Society agree to a request from the Wisconsin Division of the American Cancer Society asking SMS cooperation in seeking passage of an anti-quackery law.

Public Representation on Licensing Boards. Commission on Public Policy, February 23, agreed that the State Medical Society should support an amendment to Assembly Bill 1447 which would prohibit the appointment to the Medical Examining Board of any public representative belonging to any of the health professions or occupations.

County Traffic Committee. Commission on Public Policy, February 23, recommended that the State Medical Society support Senate Bill 458 which would create in each county a seven-member county traffic commission. Such a commission would by law have a representative of medicine.

Contacts With Legislators. Commission on Public Policy, February 23, recommended that all component medical societies have regular meetings with their legislators and be advised of the State Society's bylaw requirement that each county society have a public policy committee.

In-Depth Teaching Programs. Commission on Scientific Medicine, March 3, recommended that the In-Depth Teaching Programs of the State Medical Society be expanded during the academic year 1972–73. The University of Wisconsin Extension Division, Postgraduate Medical Education Department, would cosponsor the programs which would be presented in the present format in other cities in addition to Madison. La Crosse, Eau Claire, and the Fox River Valley area were discussed as sites for the programs.

School Bus Drivers. Commission on Safe Transportation March 7, met with representatives of the State Department of Public Instruction to discuss the development of medical standards for school bus drivers.

Catholic Physicians Breakfast. Committee on Medicine and Religion, March 9, made final plans for the breakfast, May 10, which will be cosponsored with the Catholic Physicians Guild during the State Medical Society's Annual Meeting in Milwaukee. Panel discussion on "Death."

Medicine and Religion Newsletter. Committee on Medicine and Religion, March 9, made plans for a newsletter to be compiled twice a year by the committee for mailing to committee members, county medical societies, and other interested physicians.

Society Proposes Insurance Plan to Cover Unemployed-"Uninsurables"

The State Medical Society of Wisconsin and its insurance arm, WPS Blue Shield, has proposed an innovative new health-care financing plan to help the unemployed and those whose health problems have made them "uninsurable."

Copies of the proposal are being sent to the state Legislature, Governor Lucey, and the Governor's Task Force on Health Planning and Policy. In a letter, SMS Council Chairman, E. J. Nordby, MD, said, "a proposal such as this one—if put into practice in Wisconsin—could serve as a model for the entire nation. The problem is not unique to our area, but it is one that soon must be solved nationwide."

The proposal would extend health-care benefits to the unemployed through the same mechanism that administers Unemployment Compensation Benefits. The benefits provided would be the same as those now provided under Medicaid Group II—government assistance for those who cannot meet their medical bills because of severely limited finances.

It is estimated that at any given moment there are some 18,600 unemployed in the state who need such help. They are people whose health insurance was with a group plan where they worked. Approximately 70 percent of everyone in Wisconsin has this type of health insurance.

Employer Taxation a Solution

Most health insurance companies do offer "conversion" coverage to people leaving group plans. This is usually more expensive than coverage under a group plan. Thus, at the same time a person finds himself out of work he is faced with higher insurance costs. The result is that a high percentage of the unemployed have no health insurance at all.

The State Medical Society proposes that coverage for the unemployed be provided through a slight increase in employer taxes for Unemployment Compensation. The Society proposal notes that "it seems as reasonable to tax employers for compensation for lost fringe benefits as it does for lost wages." Employers who already have health insurance conversion coverage available for former employees would no doubt have lower insurance rates if they did not need to offer such benefits.

The State Medical Society also proposes a system to insure people now considered "uninsurable" by health insurance companies. "Uninsurables" are those who have been refused health insurance because of serious pre-existing health problems.

To solve this problem, the Society suggets a system that would allow private insurers to cover "uninsurables" without competitive disadvantage. It is estimated that 10,000 to 15,000 people a year would qualify for such coverage.

The State Medical Society body which worked out the proposal is the Commission on Medical Care Plans (CMCP), which directs WPS activities as well as Medicare and Medicaid programs for most of Wisconsin.

E. M. Dessloch, MD, CMCP chairman, states that "the administrative machinery now exists to fill these needs in our health-care financing system. This help is needed by a relatively small number of people, but their need is pressing."

Milwaukee Surgeons Are 1972 "Wisconsinites"

WISCONSIN BROADCASTERS ASSOCIATION named two Milwaukee surgeons as recipients of its annual "Wisconsinite of the Year Awards" during the association's mid-winter annual meeting and seminar February 23–24 in Madison. They are MDs Derward Lepley, Jr. and W. Dudley Johnson who were cited as having dedicated their lives and their talents to rebuilding damaged hearts and extending human life spans. In 1968 Dr. Lepley headed a team, including Dr. Johnson, that performed the first heart transplant in Wisconsin and the Midwest. They have developed several new techniques in coronary surgery, including the use of vein grafts to shunt blood past totally or partially blocked areas in the heart's arteries. Dr. Lepley is clinical professor of thoracic and cardiovascular surgery at the Medical College of Wisconsin; Dr. Johnson is chief of the Department of Thoracic Surgery at St. Luke's Hospital in Milwaukee. The awards were presented to the two doctors by Andrew M. Spheeris, WBA president, shown above at the podium and flanked by Drs. Lepley and Johnson. Mr. Spheeris commented, "the contributions they have made can't be measured."

Visiting Professors Can Now Obtain Temporary License

Foreign medical school graduates who serve as visiting professors at the medical schools in Wisconsin can now be issued a temporary license to practice medicine and surgery.

Governor Lucey recently signed into law Bill 419, S., introduced by Senators Murphy, Chilsen, Devitt, and Lorge, which provides for a two-year license that may be renewed twice while the holder is serving full-time on a medical school's academic staff.

The State Medical Society had supported this legislation. The law now appears in Chapter 153 of the Wisconsin Statutes.

Traditional Crafts and Fine Arts Show

MAY 8–9–10, 1972 • EAST ROOM OF SHERATON–SCHROEDER HOTEL MILWAUKEE, WISCONSIN

CO-CHAIRMEN: Dr. & Mrs. John Smith and Dr. & Mrs. John Chamberlain

SPONSOR: Woman's Auxiliary to The State Medical Society of Wisconsin

WHO MAY EXHIBIT: Any member of the State Medical Society or spouse.

NUMBER OF ENTRIES: Limit of three entries per person.

REQUIREMENTS:
1. All pictures must be framed with wire and screw eyes attached.
2. Works of sculpture must not exceed 24 inches in height.
3. All entries must be personally delivered to the East Room, Sheraton–Schroeder Hotel, on Sunday, May 7 between 3:00 and 5:00 p.m. They must be picked up on Wednesday, May 10 between 3:00 and 5:00 p.m.

POPULARITY AWARDS: Exhibits will not be judged by a professional this year. Viewers will vote for the "Best of Art" award and "Best of Craft" award. Results will be announced Wednesday, May 10 at 1:00 p.m.

SALE OF ENTRIES: Exhibitors wishing to sell their entries may attach a card indicating this, along with their name, address, and price, so the prospective buyer may contact the exhibitor.

LIABILITY: The exhibitor must assume full responsibility for articles exhibited, but every precaution against damage or theft will be exercised.

Artwork courtesy MICHIGAN MEDICINE

ENTRY BLANK

Traditional Crafts and Fine Arts Show

Return by APRIL 25 to: Mrs. John Smith
4480 N. Lake Drive
Milwaukee, Wisconsin 53211

NAME .....

STREET .....

CITY .....

Ceramics .....

Drawings and Graphic Arts .....

Paintings .....

..... (give dimensions)

Check one: ☐ Watercolor ☐ Acrylic ☐ Oil

Photography ..... (give dimensions)

Sculpture ..... (approximate size)

Three Dimensional Design

Check: ☐ Crewel ☐ Metalwork
☐ Macrame ☐ Pottery
☐ Lapidary ☐ Weaving and Textiles
☐ Needlepoint ☐ Woodwork
☐ Other

Brief description of article: .....

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Peer Review Corp. Given $25,000 WRMP Grant

The Wisconsin Regional Medical Program (WRMP) has authorized a $25,000 developmental award to Wisconsin Health Care Review, Inc. (WHCRI) to aid it in establishing a peer review facility for Wisconsin.

WHCRI was incorporated December 29 by the State Medical Society of Wisconsin, the Wisconsin State Dental Society, and the Wisconsin Hospital Association. It is believed to be the first review organization in the country to include more than one profession—at least on a partnership basis.

In authorizing the award, the WRMP executive committee expressed the hope that WHCRI will cooperate with other peer review and quality control activities which are developing in Wisconsin.

The award money will be used to help support staff and consultative services as well as the establishment of local and district peer review counterparts.

Kenosha Medical Society Initiates Unique Doctor Recruiting Plan

A "person to person" approach has been used by the Kenosha County Medical Society (KCMS) in a new program aimed at attracting young physicians to the area to practice.

Last month KCMS invited a group of Milwaukee and Madison interns and residents and their wives to Kenosha for an overnight visit. Eight attended the program which included dinner with local physicians, hospital officials, and Kenosha's mayor and a tour of St. Catherine's and Kenosha Memorial hospitals.

Costs of lodging and meals for the guests were shared by KCMS and the two hospitals.

Raymond G. Welsch, MD, chairman of the KCMS public relations committee who guided the program, was pleased with the results.

He said, "I think everything turned out well and the appearance of so many medical society physicians for the dinner and tours was most gratifying. I am certain we will act as host for another program such as this next year. We also learned a few things and I am sure the number of guests next year will be greater."

Dr. Welsch noted that guests' questions showed they took the visit seriously and appreciated the opportunity to learn about the city, its hospitals, and its doctors.

One wife said, "If we were to settle in Kenosha in the near future, I would feel as I already knew the other doctors' wives."

The wives were taken on a tour of the city by physicians' wives and then to lunch.

Riley McDavid, president of Kenosha Memorial Hospital termed the program, "One of the best things that we have ever done to encourage young doctors to move to Kenosha. The personal contact, in both a social and a professional atmosphere, just can't be duplicated any other way."

Society Designates CMCP to Handle HMO Planning

Establishment of health maintenance organizations (HMOs) and related activities are being guided for the State Medical Society by its Commission on Medical Care Plans, which directs the health insurance program—Wisconsin Physicians Service (WPS Blue Shield). Inquiries on any aspect of this area should be directed to that Commission, which is headed by E. M. Dessloch, MD, Prairie du Chien.

Milwaukee Sentinel's Forum on Health-Care Crisis Set for May 1 in Milwaukee

"The Health Care Crisis" will be the theme for the 9th Annual Forum for Progress, sponsored by the Milwaukee Sentinel, to be held May 1 at the Milwaukee War Memorial Center in Milwaukee.

Major topics for discussion will include "Health Care in the 70's," "The Health Crisis in Wisconsin," "The Pros and Cons of a National Health Insurance," and "The Consumer and the Health Care Crisis."

Luncheon speaker will be the Hon. John G. Veneman, Under Secretary of the Dept. of HEW.

An audience of some 600 persons is expected, including many distinguished leaders from Milwaukee and throughout Wisconsin. The medical profession is expected to have strong representation.

Chinese Medicine is Topic of UW Program

"Modern China and Traditional Chinese Medicine" is the subject of a free April 15 University of Wisconsin program open to the public.

Speakers will include physicians and faculty members from across the country representing medicine, history, and East Asian research.

The program includes historical and modern looks at traditional Chinese medicine as well as panel discussion on Chinese acupuncture and modern Chinese health care delivery.

Sessions will be held from 10 a.m. through 9 p.m. in the Lowell Hall auditorium, 610 Langdon St., Madison. Cosponsors are the University of Wisconsin Center for Health Sciences and the History of Medicine Department.

Reservations for the $2.50 luncheon and the $4.25 Chinese dinner buffet being held in conjunction with the program must be made no later than April 10. Checks should be sent to the University of Wisconsin, Coordinator of Postgraduate Medical Education, 702 Langdon Street, Madison. A cash bar social hour will be held in the Lowell Hall dining room at 5:45 preceding the dinner.

Plan Allied Health Congress

A preliminary meeting to plan the First Wisconsin Congress for Allied Health Professionals will be held April 8 at the Medical College of Wisconsin.

NEWS HIGHLIGHTS

Dr. Mason, Sheboygan, Feted

On the occasion of his birthday, Paul B. Mason, MD,* was honored by members of The Sheboygan Clinic staff, their wives and friends, at a festive gathering at the Pine Hills Country Club in January.

Doctor Mason was cited for outstanding leadership provided to the clinic organization. Since 1943, Doctor Mason has served continuously on the executive committee and was elected to serve as president of the association in 1955, a position he held until this year.

Paul B. Mason, MD

As reported in the *Sheboygan Press,* Doctor Mason has been a member of the board of directors of The Clinic Building Company throughout these years and has served as secretary–treasurer for many years.

During his tenure of office, The Clinic was extensively remodeled in 1947–1948 with further additions to the building and an expansion project completed in 1964–1965 and again in 1971.

Dr. Mason has been a prime counselor and leader of the entire clinic staff. He has devoted many hours to resolving business matters on the executive and staff levels.

In the area of state leadership, Doctor Mason has been active in the State Medical Society of Wisconsin and other organizations concerned with medical care. As a member for many years of the State Medical Society's Commission on Medical Care Plans, he has provided leadership and guidance in the direction of the Society's Blue Shield plan, Wisconsin Physicians Service (WPS Blue Shield).

Doctor Mason's latest involvement is his recent appointment as president of the board of directors of the newly incorporated Wisconsin Health Care Review, Inc., an organization designed to act as a monitor of relationships among patients, health care providers, and the groups which pay most of the bills, such as insurance companies and government agencies—a statewide peer review mechanism which also involves the state dental and hospital associations as well as the medical society.

Doctor Mason joined The Sheboygan Clinic staff in 1936 after completing a residency in internal medicine at the Mayo Clinic in Rochester, Minn. He was presented a number of gifts in appreciation of past services. He plans to continue his practice on a full-time basis.

Other members of the medical staff were also recognized for their past services: James F. Hildebrand, MD* was given a wrist watch in recognition of 25 years of service. He joined the staff in 1947, and is certified by the American Boards of Dermatology and Internal Medicine. Doctor Hildebrand limits his practice to dermatology.

Jerry W. McRoberts, MD,* a general surgeon, received a congratulatory gift upon completion of 35 years of service. He served as president of the State Medical Society of Wisconsin from May 1970 to May 1971. He also is a past president of The Clinic, having served several terms, and was a member of its executive committee for over 20 years. Doctor McRoberts was honored last summer at a special recognition dinner.

PHYSICIAN BRIEFS

Gerald E. Porter, MD*

. . . Marshfield, recently was reelected chief of the medical staff at St. Joseph's Hospital. Elected vice-chief of staff were MDs William V. Dovenbarger* and Raymond E. Burrill* as secretary.

Eugene J. Valentini, MD

. . . La Crosse, recently joined the medical staff of St. Francis Hospital, La Crosse, as a radiologist. He graduated from Washington University Medical School, St. Louis, Mo. and completed his residency at the University of Minnesota.

John E. Hamacher, MD*

. . . Madison, recently was appointed secretary of the newly formed Section on Plastic Surgery of the State Medical Society. Gordon Davenport, Jr., MD,* Madison is the chairman.

Paz G. Melich, MD

. . . New Richmond, recently opened offices in New Richmond. Doctor Melich, a diplomate of the American College of Obstetricians and Gynecologists, graduated from the University of the Philippines and interned at Bellevue Hospital, New York. Prior to coming to New Richmond, she had practiced in St. Paul, Minn.

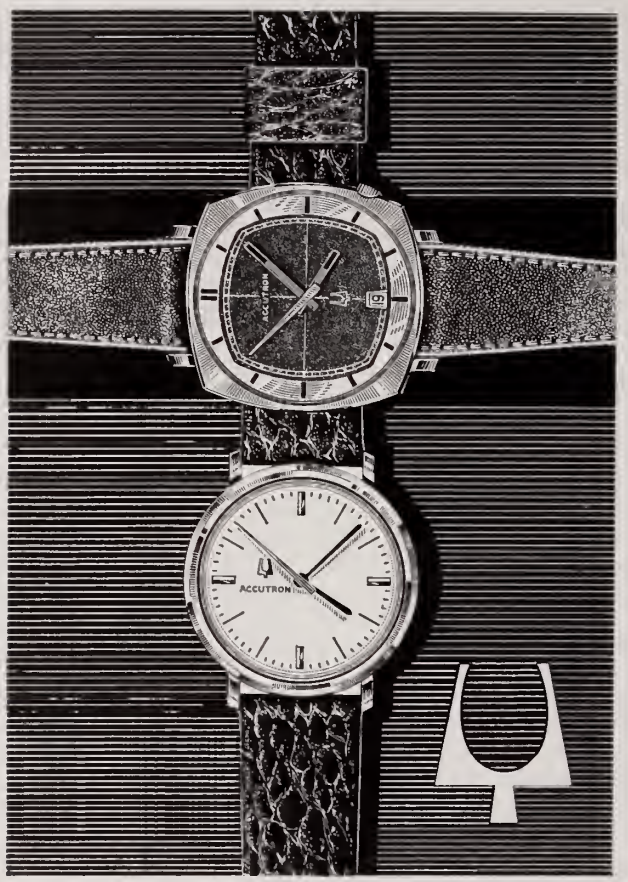
James F. Bigalow, MD*

. . . of Merrill is still the Lincoln County Medical Society's delegate to the State Medical Society. It was erroneously published in the December issue that N. L. Bugarin, MD* of Tomahawk was the newly elected delegate.

William P. McInnis, MD

. . . Marion, chief of staff of the Clintonville Community Hospital, recently was named a fellow of the American Academy of Family Physicians. He has practiced medicine in Marion for 20 years.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.



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William Curtis, MD*

. . . Elm Grove, recently was honored at a "Hats Off to Dr. Curtis" night held by staff physicians and their wives. Doctor Curtis was chief of staff of Elmbrook Memorial Hospital for the past nine years, including the years at Misericordia Hospital when planning was being done for the present hospital. He has been noted for establishing the emergency service as well as assisting in the planning of the general hospital medical services. Doctor Curtis served as secretary of The Medical Society of Milwaukee County in 1963 and also as president of the Wisconsin Academy of Family Physicians.

Harold H. Scudamore, MD

. . . formerly of the Mayo Clinic, Rochester, recently joined the medical staff of The Monroe Clinic. Doctor Scudamore had been consultant in medicine at the Mayo Clinic and associate professor of medicine in the Mayo Graduate School of Medicine of the University of Minnesota. He has maintained a special interest in diseases of malabsorption and of the intestines, and was recipient of a William H. Rorer, Inc., award for a paper which he presented at the meeting of the American College of Gastroenterology in 1968.

Thomas W. Grossman, MD*

. . . Milwaukee, recently assumed the post of president of the medical staff of St. Mary's Hospital. John C. Linn, MD* was named vice-president and Alfred Meyers, MD,* was elected secretary-treasurer. Chairman of the departments are MDs John J. Haugh,* surgery; M. C. F. Lindert,* medicine; Thomas J. Cox,* general practice; Avadh B. Agarwal,* pediatrics; and William C. Fetherston,* obstetrics-gynecology.

James F. Zimmer, MD*

. . . Hales Corners, recently took office as president of St. Luke's Hospital medical staff. MDs Donald J. Albrecht,* West Allis, was elected to a two-year term as president-elect and John E. Cordes,* Elm Grove, was re-elected as secretary-treasurer.

Robert Krohn, MD

Robert Krohn, MD*

. . . Black River Falls, a founder of the Krohn Clinic and chief of staff at Black River Memorial Hospital, retired February 1. Doctor Krohn's services will be available to the hospital and clinic if needed; he will remain vice-chairman of the State Medical Society's Commission on Medical Care Plans, and he will continue as Jackson County coroner. He graduated from the University of Illinois School of Medicine, Chicago, and served two years with the United States Navy. In 1931, he started the Krohn Clinic and Hospital with his father and brother, the late Dr. Irwin Krohn, and in 1932 the Clinic was completed along with an eight-bed hospital. The eight-bed hospital at the clinic grew into a 53-bed hospital during the 1950s, which later gave way to the present 76-bed Black River Memorial Hospital which was dedicated in 1968. Doctor Krohn is a member of the hospital's board of directors. In 1958, Doctor Krohn was elected to a fellowship in the International College of Surgeons, and in 1959 he was elected to the American Society of Abdominal Surgeons.

Fred J. Ansfield, MD*

. . . Madison, professor in the Division of Clinical Oncology at the University of Wisconsin Medical Center, will participate in the 14th Western Cancer Seminar to be held in Las Vegas, Nev., on April 10–11. His topic will be "Head and Neck Chemotherapy."

Stephen H. Ambrose, MD*

. . . recently was recognized for his 18 years of service as physician at the University of Wisconsin–Whitewater. The student health center has been named in his honor. The $700,000 two-story structure is the first health facility especially designed, built, and equipped to serve student needs in what was the Wisconsin State University System, before merger. Doctor Ambrose retired from his campus post in 1964 in order to limit his practice to private patients.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1972

1	Madison General Hospital Surgical Staff
1	Madison Urological Society
1	Madison Anesthesiology Society
1	Dane County Medical Society Board of Trustees
2	Family Planning Institute
2	Board of Directors, Madison Chapter of American Management Society
3	Madison and Area Otolaryngologists Seminar
4	Peer Review Study Committee
7	Dane County Medical Society Insurance Advisory Committee
9	SMS Committee on Occupational Health
9	Executive Committee, SMS Section on Ophthalmology
11	Finance Committee of SMS Council
12	Preceptors and Faculty, University of Wisconsin Medical School
16	Board of Trustees, SMS Realty Corporation
17	Executive Committee of SMS Commission on Medical Care Plans
18	Wisconsin Otolaryngological Society
19	Wisconsin Otolaryngological Society
23	SMS Commission on Public Policy
26	Finance Committee and Planning Committee of SMS Council and AMA Delegates Caucus
26	SMS Council
27	SMS Council
27	SMS Realty Corp.

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Philip M. Marden, MD*

. . . Watertown, who previously was associated with the Wilkinson Clinic in Oconomowoc, has opened a full-time practice in pediatrics in Watertown. A graduate of the University of Wisconsin Medical School, he completed a two-year residency at the University of Minnesota and then had a fellowship there for an additional year of specialized training. Doctor Marden did two years of duty in the Public Health Service in Arlington, Va., and returned to the University of Wisconsin to become a faculty member of the pediatrics department. While in Oconomowoc, Doctor Marden initiated and directed the establishment of a type of community health council which worked with him in the writing of two important pediatric health manuals for parents and has assisted with the production of tapes and film strips to be used in child development courses and in hospitals.

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Milwaukee Academy of Surgery

. . . recently elected the following officers: president—Morrison Schroeder, MD;* president-elect—Shimpei Sakaguchi, MD;* members of governing council—MDs George F. Flynn,* John J. Frederick,* and John D. Riesch.* Reelected were Donald P. Davis, MD,* secretary–treasurer; and James F. Zimmer, MD,* recorder.

Wisconsin Dermatological Society

. . . recently elected Robert R. Baumann, MD* of Monroe as its president. Doctor Baumann also was named chairman of the Section on Dermatology of the State Medical Society of Wisconsin. He is in the Department of Dermatology, The Monroe Clinic, and is an assistant clinical professor of dermatology at the University of Wisconsin Medical School.

Milwaukee Gastroenterological Society

. . . held its annual dinner dance at the University Club of Milwaukee January 15. The following officers were installed: K. H. Soergel, MD, Milwaukee, president (1971–1972), and J. E. Geenen, MD,* Racine, secretary–treasurer (1972–1973).

The Adolph Gundersen Medical Foundation

. . . and the Wisconsin Heart Association will hold the Seventh Annual Fall Cardiovascular Symposium October 25 at the University of Wisconsin—La Crosse. Subject for this year is "Congestive Heart Failure" and the format will be the same as in previous years—one-day symposium with five prominent speakers in the morning and a panel discussion in the afternoon. A. Erik Gundersen, MD* is in charge of arrangements. □

James T. Duncan, MD*

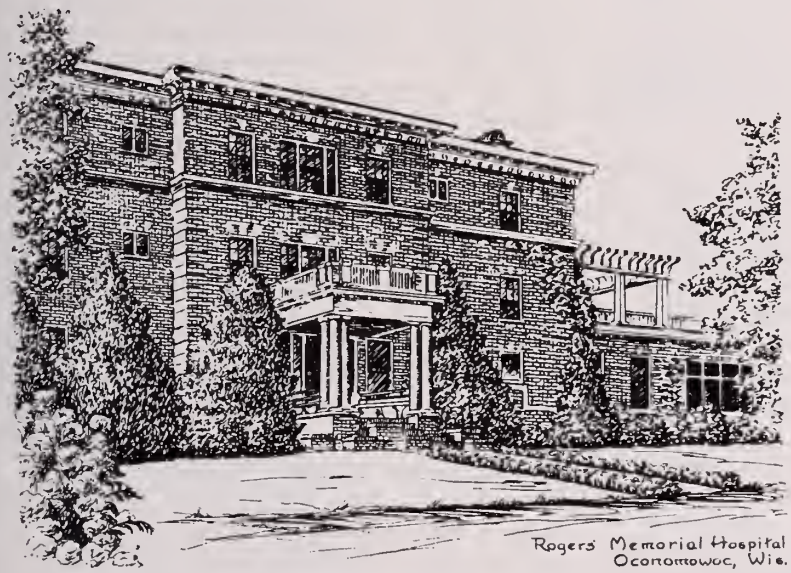
. . . Kenosha, was elected president of the Memorial Hospital medical staff. Also elected were MDs Harold C. Kappus,* vice-president; Reinaldo Barreto,* secretary; Walid Burhani,* Louis Olsman,* and Hugh P. Rafferty,* all of Kenosha, were elected to the executive board.

John W. Doty, MD*

. . . Ashland, recently joined the Ashland Clinic. Formerly associated with the Dean Clinic, Madison, Doctor Doty is a graduate of the University of Wisconsin Medical School, served his internship at San Joaquin County General Hospital, Stockton, Calif., and completed his residency at the University of Wisconsin Medical Center. Doctor Doty also has been assistant clinical professor of ophthalmology at the University of Wisconsin Medical Center.

Nicholas G. Papadakes, MD*

. . . Janesville, recently was inducted as a fellow of the American Academy of Orthopaedic Surgeons. □



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SECTION OPHTHALMOLOGY

MARCH 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

EYE INSTITUTE FUND CAMPAIGN UNDERWAY

The Medical College of Wisconsin (MCW) recently announced that John H. Kopmeier had been named to head the campaign steering committee to raise funds for construction of the Eye Institute of the MCW, and that William B. Murphy had accepted the committee's vice-chairmanship. Mr. Kopmeier is president of Hometown, Inc. of Milwaukee, and Mr. Murphy is a vice-president of Robert W. Baird & Co. Over $1 million of the committee's $2.8 million goal already has been pledged.

Other steering committee members are Edmund Fitzgerald, retired chairman of the board, Northwestern Mutual Life Insurance Co.; Joseph Heil, Sr., chairman of the board, The Heil Co.; John M. Nuzum, retired chairman of the board, First Wisconsin Trust Co.; Louis Quarles, senior partner of the law firm of Quarles, Herriott, Clemons, Teschner and Noelke; Robert S. Stevenson, retired chairman of the board, Allis–Chalmers; and Carlton P. Wilson, president, Robert W. Baird & Co. Messrs. Kopmeier, Heil, Quarles, Stevenson, and Wilson also are members of the MCW Board of Directors.

The steering committee has been conducting a private campaign among persons in the Milwaukee community who have an expressed interest in eye research, education, and treatment.

Members of a committee of practicing ophthalmologists which has been formed to assist in the fund raising efforts are John B. Hitz, MD, chairman; Samuel S. Blankstein, MD, vice-chairman; James V. Bolger, MD, Harry A. Easom, MD; Clemens G. Kirchgeorg, MD; Thomas R. Sawyer, MD; and Richard O. Schultz, MD. Both the Milwaukee Ophthalmological Society and the Milwaukee Ophthalmic Institute have indicated their support of the campaign.

Funds are earmarked for the construction of an eye research and treatment center adjoining Milwaukee County General Hospital.

Campaign costs are being underwritten by Research to Prevent Blindness, a national organization dedicated to supporting a research attack against blindness.

Construction of the eight-story building, which has been designed to meet the needs of eye research, teaching, and patient care, is scheduled to begin early this year.

The Institute will be staffed by members of the faculty of the MCW Department of Ophthalmology under the direction of Richard O. Schultz, MD, professor and department chairman. In recent years this department has developed its training program into one of the largest in the country. Research work now being done by faculty members includes studies on freeze preservation of corneal tissue for transplant surgery, studies of the causes of retinal detachment, glaucoma research, and the investigation of new drugs for treating infectious eye diseases.

Patient care including hospitalization and outpatient services, will be supplied similarly to ophthalmology programs now carried out within Milwaukee County General Hospital.

The MCW ophthalmology faculty has established and staffed various special service clinics throughout the Milwaukee community, many of which will be consolidated in the new Eye Center. The Center is expected to provide a backup resource for eye doctors throughout the upper Great Lakes region. As a referral facility and through outpatient clinics in its affiliated hospitals, the eye department now provides care to nearly 40,000 patients a year. More than 2,000 major eye operations are performed annually.

The Eye Institute campaign is phase one of a $14 million fund raising program called "Project 75." The major thrust of this total campaign will be to provide matching funds to build a new Basic Science Building for MCW, to be constructed by 1975 at the Medical Center of Southeastern Wisconsin.

NEW OPHTHALMOLOGIST IN LA CROSSE

Karl P. Grill, MD has joined Bernard J. Mansheim, MD in the practice of ophthalmology at the La Crosse Clinic Ltd. in La Crosse. Doctor Grill received his undergraduate degree in metallurgical engineering from the University of Wisconsin in 1955. After four years in this field he returned to the University of Wisconsin in Madison and received his MD degree in 1964. After returning from Viet Nam, he took an ophthalmology residency at the Mayo Clinic, completing his studies in July 1971. He then spent three months at the Guinness Eye Clinic, Kaduna, Nigeria, before joining the La Crosse Clinic Ltd.

RETINA FELLOW IN MILWAUKEE

Harold Berger, MD recently started a retina fellowship at the Medical College of Wisconsin, Milwaukee. Doctor Berger spent several years in private practice of ophthalmology in Miami, Fla., prior to starting his retina fellowship. □

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OBITUARIES

Herbert W. Strass, MD, 84, Milwaukee, died Sept. 10, 1971, in Milwaukee.

Born on Dec. 22, 1886, in Marinette, Doctor Strass graduated from the Northwestern University Medical School in 1910 and served his internship at Chicago Lying-In Engelwood General Hospital. He served in World War I in the United States Army Medical Corps.

Doctor Strass was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Helen.

Ralph Towns Gilchrist, MD, 89, Fort Atkinson, died Dec. 17, 1971, in Fort Atkinson.

Born on Mar. 19, 1882, in Oskaloosa, Ia., he graduated from Rush Medical College, Chicago, in 1910 and served his internship and residency at Milwaukee County Hospital. Doctor Gilchrist served in the Army Medical Corps in France during World War I and was a retired lieutenant colonel in the Army Reserve Medical Corps. He was assistant medical director for Northwestern Mutual Life Insurance Co., Milwaukee, before retiring in 1952.

Doctor Gilchrist was a member of the American Academy for the Advancement of Science, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Anne; a son, Ralph E., Houston, Tex.; and a daughter, Mrs. Frederick Hobe, Fort Atkinson.

Madeleine Kovacs, MD, 72, former Milwaukee psychiatrist, died Dec. 18, 1971, in Miami Beach, Fla.

Born on March 23, 1899, in Budapest, Hungary, Doctor Kovacs graduated from the University of Budapest Medical School in 1924 and interned at the State Hospital, Budapest.

There are no immediate survivors.

Gale Waite Huber, MD, 79, Minocqua, died Dec. 18, 1971, at Woodruff.

Born on Mar. 10, 1892, in Merrill, Wis., Doctor Huber graduated from Loyola Medical School in 1915 and interned at Detroit Receiving Hospital, Detroit, Mich. He served in the United States Army Medical Corps during World War I and began his practice in Minocqua in 1919. Doctor Huber served the Lakeland area for more than 50 years and was instrumental in establishing Lakeland Memorial Hospital in Woodruff.

He was a member of the Oneida–Vilas County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, Gale C., Piqua, Ohio.

Sara G. Geiger, MD, 79, formerly of Milwaukee, died Dec. 21, 1971, in Tipton, Ia.

Born on Jan. 18, 1892, in Tipton, Ia., Doctor Geiger graduated from Rush Medical School in 1923 and served her internship and residency at Children's Memorial Hospital, Chicago, Ill., and at Sheppard and Enoch Pratt Hospital, Towson, Md., respectively. She was associated with the county guidance clinic for 25 years in Milwaukee and the clinic director before entering private practice in 1961.

Surviving is a sister, Marguerite, Tipton, Ia.

Gordon J. Schulz, MD, 66, prominent Union Grove physician for over 38 years, died Dec. 26, 1971, in Racine.

Born on Nov. 20, 1905, in Milwaukee, Doctor Schulz graduated from Marquette University School of Medicine in 1931 and served his internship and residency at Columbia Hospital and Johnston Emergency Hospital in Milwaukee.

Active in community affairs, Doctor Schulz served as the president of the Racine County Medical Society in 1947

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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969

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Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

N.A. = Not Available Commercially

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(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) for **Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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Address

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and was chief of staff at St. Mary's Hospital, Racine for two years.

Elected as a councilor of the State Medical Society of Wisconsin in 1960, he served the Society for nine years. He also was treasurer of the Society's Charitable, Education and Scientific Foundation for a number of years. Doctor Schulz retired from practice in 1971. He was a member of the American Academy of Family Physicians and the American Medical Association.

Surviving are his widow, Rhea; two sons, John, Racine, and Richard, Mequon; and a daughter, Mrs. Jane Moulten, Des Moines, Ia.

James Henry Murphy, MD, 77, Oshkosh, died Jan. 9, 1972, in Oshkosh.

Doctor Murphy practiced in Clintonville, Wis., for a number of years. From 1949–1956, he served on the medical staff of the Winnebago State Hospital and from 1956–1963, he was chief surgeon at the Veterans Hospital at King, Wis. He retired in 1963.

Ernest S. Olson, MD, 70, Racine, died Jan. 10, 1972, in Racine.

Born on Mar. 24, 1901, in Lemont, Ill., Doctor Olson graduated from Rush Medical College, Chicago, in 1930 and served his internship at Los Angeles County General Hospital. During World War II he served in the United States Army Medical Corps as a Lieutenant Colonel.

Doctor Olson was pathologist in charge of Clinical Laboratory at VA hospitals in Aspinwall, Pa., Dayton, Ohio, and the Bronx, N. Y., before becoming director of Clinical Laboratory Services and chief pathologist at St. Luke's Hospital, Racine, in 1949. In 1969, he resigned his position but remained on the laboratory staff at St. Luke's as pathologist emeritus until his death. He also was on the staff of Burlington Memorial and Highridge hospitals. Doctor Olson was a diplomate of the American College of Pathologists, and a member of the American Society of Clinical Pathologists, Wisconsin Society of Pathologists, American Association of Blood Banks, and International Society of Blood Banks. He also was a past president of the Wisconsin Association of Blood Banks and editor of the WABB *Bulletin*. He has written many medical articles and was awarded an honorary membership in the Milwaukee Academy of Medicine.

Doctor Olson was a member of the Racine County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lillian; two daughters, Mrs. G. Edward (Marilyn) Birchfield, Evanston, Ill., and Mrs. Roy (Lillian) Mackal, Chicago, Ill.; and two sons, Ernest, Jr., Switzerland, and Dr. Charles Olson, Modesto, Calif.

Thomas A. Judge, MD, 87, Milwaukee, died Jan. 22, 1972, in Milwaukee.

Born on July 26, 1884, in Forest Junction, Wis., Doctor Judge graduated from the St. Louis University School of Medicine in 1908 and served his internship at St. John's Hospital, Fargo, N. D. He retired in 1965 after 47 years of practice. In 1934, he was president of the Milwaukee Society of Ophthalmology and Otolaryngology and chief of staff at St. Mary's Hospital, Milwaukee.

Doctor Judge was a member of the American Academy of Ophthalmology and Otolaryngology, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Florence; and two sons, Thomas A. Jr., Fox Point, and Richard D. Judge, MD, Ann Arbor, Mich. □

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SOCIETY RECORDS

CORRECTION

The January Blue Book issue contained errors in the membership listing involving Doctors William L. Lorton and Rhoda J. Lorton. Doctor William Lorton's name did not appear in the listing and his wife, Doctor Rhoda Lorton, was listed twice in two different ways—in the Milwaukee section as R. E. Lorton and Rhoda J. Lorton. Doctor Lorton's wife is the former Rhoda E. Johnson whom he married in September 1970. They prefer their membership to be listed according to their licensure as follows: William L. Lorton, MD, Milwaukee, and Rhoda E. Lorton, MD, Milwaukee, since they live and have offices in Metropolitan Milwaukee although their address is: 1220 Dewey Ave., Wauwatosa, Wis 53213.

MEMBERSHIP REPORT AS OF JANUARY 31, 1972

NEW MEMBERS

Aguila, Demetrio A., Jr., 2900 West Oklahoma Ave., Milwaukee 53215
Anderson, Robert C., 611 Sherman Ave., Fort Atkinson 53538
Chen, Hong-Mo, 630 S. Central Ave., Marshfield 54449
Cohen, Roger D., 9073 North Bayside Dr., Bayside 53217
Cripps, Derek J., 1300 University Ave., Madison 53706
Douglas, Eustace, 2506 N. 124th St., #122, Wauwatosa 53226
Frey, William B., 1515—10th St., Monroe 53566
Gilbertson, Gary F., 630 South Central Ave., Marshfield 54449
Hayl, Bruce A., 610 E. Longview Dr., Appleton 54911
Hung, Glen Por-yuan, 123 Hospital Dr., Watertown 53094
Khan, A. Hamid, 630 South Central Ave., Marshfield 54449
Kirsch, John M., 1515—10th St., Monroe 53566
Mangru, Bala, 803 West 11th St., Altoona 54720
Mitchell, John H., 630 South Central Ave., Marshfield 54449
Nolasco, Thomas C., Jr., 8700 West Wisconsin Ave., Milwaukee 53226
Numsen, Gene, 4431 S. Sacramento Ave., Chicago, Ill. 60632
Patten, James T., 3363 North Knoll Blvd., Wauwatosa 53222
Pousti, Ahmed, 630 South Central Ave., Marshfield 54449
Raich, Peter C., 202 South Park St., Madison 53715
Saggio, Carl J., 1990 Reinhardt Rd., Fond du Lac 54935
Scudamore, Harold H., 1515—10th St., Monroe 53566
Teruel, Serafin B., 1969 West Hart Rd., Beloit 53511
Williamson, George D., 630 South Central Ave., Marshfield 54449

CHANGE OF ADDRESS

Clarke, Gary S., 4406 South Napa, Spokane, Wash. 99203
Currie, Robert E., P. O. Box 218, Kenosha 53140
Harbour, Jeanne D., 1301 North Western Ave., Lake Forest, Ill. 60045
Kabler, J. D., 1552 University Ave., Madison 53706
Marden, Philip M., 123 Hospital Dr., Watertown 53094
Owen, Russell H., P. O. Box 2088, Appleton 54130
Pulito, Frank J., 5000 West National Ave., Wood 53193

DEATHS

Murphy, James H., nonmember, Jan. 9, 1972
Olson, Ernest S., Racine County, Jan. 10, 1972
Comstock, Elizabeth, Trempealeau–Jackson–Buffalo County, Jan. 15, 1972
Keland, Harold B., Racine County, Jan. 17, 1972
Judge, Thomas A., Milwaukee County, Jan. 22, 1972
Leibenson, Samuel J., Winnebago County, Jan. 30, 1972
Schwartz, Gilbert J., Kenosha County, Jan. 31, 1972 □

Pre-Sate®
(chlorphentermine HCl)

CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
Full information available on request.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

Mar. 31, Apr. 1: Seventh Annual Teaching Days in Sports Medicine, University of Wisconsin Department of Postgraduate Medicine, Wisconsin Center, Madison.

Mar. 31–Apr. 1: Midwest Chapter, College of Sports Medicine Meeting, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 13–15: *Advances in Pediatric Radiology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–10: Wisconsin Clinic Managers Association, Downtowner Motor Inn, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Applied Genetics for the Clinician Conference, Wisconsin Center, Madison. Info: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

1972 NEIGHBORING STATES

Apr. 15: Symposium on Dealing with the Adolescent Patient, sponsored by the West Bank Medical Center (Fairview Hospital and St. Mary's Hospital) of Minneapolis, Minn., at Fairview Hospital. INFO: Dorothy Bernstein, MD, Director, Adolescent Treatment Unit, Fairview Hospital, 2312 S. 6th Street, Minneapolis, Minn. 55406; tel. 332–0282, ext. 273.

Apr. 17–19: 2nd Annual Great Lakes Health Congress—Health Industries Association, Mid-America Assembly, and Tri-State Hospital Assembly. McCormick Place-on-the-Lake, Chicago, Ill. Info: Great Lakes Health Congress, 400 North Michigan Avenue, Chicago, Ill. 60611. (Phone: 312/321–0317)

Apr. 27–28: Region III Seminar of American Foundation for the Blind, Pheasant Run Inn, St. Charles, Ill. Seeks to carry forward services in such areas as medical and health, social welfare, rehabilitation, home assistance, recreation and transportation . . . to improve the economic and social status of the nation's aging blind population.

May 10–13: Postgraduate course on Fractures and Other Trauma, by Chicago Committee on Trauma of American College of Surgeons, Sheraton–Chicago Hotel, Chicago, Ill.

July 21–22: Annual Session, North Central Region, American Association of Medical Clinics, Holiday Inn, Urbana, Ill. INFO: John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

1972 AMA

Apr. 6–8: Sixth National Congress on the Socio-Economics of Health Care, Ft. Lauderdale, Fla.

Apr. 24–25: Congress on Environmental Health, The Biltmore Hotel, Los Angeles, Calif.

June 18–22: Woman's Auxiliary 50th Anniversary, Convention, St. Francis Hotel, San Francisco, Calif.

June 18–22: AMA Annual Meeting, St. Francis Hotel, San Francisco, Calif.

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1973 WISCONSIN

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

* * *

William Snow Miller Medical History Seminar, May 17, Room 109 at the Union South, 227 N. Randall at 8:00 pm. Sponsored by the Department of the History of Medicine, University of Wisconsin Center for Health Sciences. Guest lecturer: Dr. Lester S. King, Senior Editor of the JAMA. Title: "Becoming a Doctor: Seven Centuries of Struggle." Public invited. Lecture to be preceded by social hour at 6:00 pm and dinner at 6:45 pm. Information and dinner reservations: Call Department of History of Medicine—(608) 262–1460.

American Association of Medical Clinics, North Central Region, will hold its annual session July 21 and 22 at the Holiday Inn, Urbana, Ill. The meeting will be hosted by the Carle Clinic Association, Urbana, and will commence with an afternoon registration period, Friday, July 21.

The two-day session will include panel discussions on: (1) computers in medicine, (2) physicians' assistants, and (3) clinics and medical education.

All interested physicians, clinic administrators, and observers are invited to attend. Additional information may be obtained by contacting John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

The North Central Region of the AAMC includes the following states: Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, North Dakota, South Dakota, and Nebraska.

continued on next page

Beloved Professor

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$2.00 per copy

Copies may be obtained from the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

National Hospital Safety Seminar, sponsored by the National Safety Council, will be held at Stouffer's Inn, Indianapolis, Ind., May 1–3 on the subject: *Patient Safety and Preventive Medicine As It Applies to Safety*. Speakers on the various panels will deal with the application of the Occupational Safety and Health Act in the field of hospital safety. Preregistration will end March 30. Total cost of the seminar, including breakfasts and a dinner banquet, is $25 per registrant. Those who wish to preregister should direct their correspondence to: Mr. Phil Weiner, The National Safety Council, 425 North Michigan Ave., Chicago, Ill. 60611.

National Conference on Cancer Chemotherapy, sponsored by American Cancer Society, National Cancer Institute, at The Biltmore Hotel, New York City, June 1–3, 1972. All members of the medical and related professions, research investigators, and medical students are invited to attend. No registration fee. Preregistration requested. INFO: Sidney L. Arje, MD, Coordinator, National Conference on Cancer Chemotherapy, % American Cancer Society, 219 East 42nd Street, New York, NY 10017.

Symposium on Dealing with the Adolescent Patient, sponsored by the West Bank Medical Center (Fairview Hospital and St. Mary's Hospital) of Minneapolis, Minn., at Fairview Hospital, Saturday, April 15, from 9 am to 5 pm. Invitation extended to any physician, especially general or family practitioner. Application to Dorothy Bernstein, MD, Director, Adolescent Treatment Unit, Fairview Hospital, 2312 S. 6th Street, Minneapolis, Minn. 55406. Registration fee $10 includes luncheon. Students and Residents are invited as guests, but are requested to register. (Tel. 332–0282; ext. 273)

American Association for Automotive Medicine, Sixteenth Annual Conference at the Carolina Inn, Chapel Hill, NC, October 18–21, 1972. Proposal of a paper for presentation is due April 15 to: John D. States, MD, Chairman AAAM Program Committee, 15 Prince St., Rochester, NY 14607. Areas of special interest with regard to medical aspects of traffic safety which may suggest a subject: (1) driver standards—licensing, (2) alcohol and drugs, (3) visual, (4) emergency medical services, (5) protective helmets and clothing, (6) restraint systems, active and passive, (7) motorcycles, (8) vehicle design, (9) medicolegal, and (10) data collection and analysis. INFO: James L. Weygandt, MD, President-elect, AAAM, 716 Monroe Street, Sheboygan Falls, Wis. 53085.

National Conference on Human Values & Cancer, sponsored by the American Cancer Society, at Regency Hyatt House, Atlanta, Ga., June 22–24, 1972. This Conference will be concerned with understanding the problems of the cancer patient from inception of disease to cure or failure. Also, the effects on the family and professionals who are directly concerned. Emphasis will be placed on the humanistic problems of the patient including interpersonal relationships, rehabilitation, employability, insurability, the right to know, the spiritual needs, and the hopes for miracles. Members of the medical and related professions, and other individuals concerned with the cancer patient are invited to attend. No registration fee. Preregistration is requested. INFO: William M. Markel, MD, National Conference on Human Values & Cancer, American Cancer Society, Inc., 219 East 42nd Street, New York, NY 10017.

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

Rehabilitation Medicine. By Howard A. Rusk, MD, The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 687 pages. Price: $21.00.

Archives of Internal Medicine Symposia. Vol. 9. Symposium on Pollution and Lung Biochemistry, guest editor, Daniel B. Menzel, PhD. American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610. 1971. 279 pages. Price: $3.50.

Doctor and Patient and the Law. By R. Crawford Morris and Alan R. Moritz. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 554 pages. Price: $24.50.

Synopsis of Ophthalmology. By William H. Havener. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 553 pages. Price $12.75.

Shands' Handbook of Orthopaedic Surgery. By R. Beverly Raney, Sr., & H. Robert Brashear, Jr. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 543 pages. Price: $15.50.

Ellison's Atlas of Surgery of the Stomach and Duodenum. By Larry C. Carey and Robert H. Albertin. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 165 pages. Price: $24.50.

Handbook of Poisoning. By Robert H. Dreisbach. Lange Medical Publications, Los Altos, California. Seventh Edition. 1971. 515 pages. Price: $6.00.

Biochemical Profiling in Diagnostic Medicine. By Joseph Preston, MD and David Troxel, MD. Technicon Instruments Corporation, Tarrytown, N. Y. 10591. 1971. 51 pages.

High Altitude Physiology: Cardiac and Respiratory Aspects. Edited by Ruth Porter and Julie Knight. Ciba Foundation Symposium. The Williams & Wilkins Company, 428 E. Preston St., Baltimore 2, Maryland 21202. 1971. 196 pages.

Early Disease Detection—II: Health Screening in Private Practice. Proceedings of the Second International Symposium on Early Disease Detection. Published by Symposia Enterprises of North Miami, Fla. 1971. Available from Futura Publishing Co., Inc., 295 Main St., Mount Kisco, N. Y. 10549. 69 pages.

Strategy of the Viral Genome. Edited by G. E. W. Wolstenholme and Maeve O'Connor. Ciba Foundation Symposium. The Williams & Wilkins Company, 428 E. Preston St., Baltimore 2, Maryland 21202. 1971. 406 pages.

Approach to the Medical Care of the Sick Newborn. By Sophie H. Pierog, MD and Angelo Ferrara, MD. The C. V. Mosby Co., St. Louis, Mo. 1971. 292 pages. Price: $11.50.

Instructional Course Lectures. Vol. XX. By the American Academy of Orthopaedic Surgeons. The C. V. Mosby Co., St. Louis, Mo. 1971. 244 pages. Price: $20.00.

Current Diagnosis & Treatment. By Marcus A. Krupp, MD and Milton J. Chatton, MD. Lange Medical Publications, Los Altos, Calif. 1972. 962 pages. Price: $11.00.

Modern Treatment. Vol. 8, No. 4. Chronic Arthritis, guest editor, J. Claude Bennett, MD. Anorectal Diseases, guest editor, Stuart T. Ross, MD. Harper & Row, Publishers, Inc., 49 East 33 St., New York, N. Y. 10016, November 1971. Issued quarterly. Price: $20.00 per year.

Fundamentals of Athletic Training. A joint project of the National Athletic Trainers Association, the Athletic Institue and the Medical Aspects of Sports' Committee of the American Medical Association. American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610. 1971. 128 pages. Price: $2.00.

There Is a Cure for the Common Cold. By Edme Regnier, M. D. Parker Publishing Company, Inc., West Nyack, New York. 1971. 202 pages. Price: $6.95.

Modern Treatment. Vol. 8, No. 3. Current Status: The Management and Treatment of Poisoning, guest editor; Jay M. Arena, MD. Special articles: Current Treatment of Potential Tetanus, The Current Status of Digitalis Therapy, and The Eye as a Mirror to Neurologic Disease. Harper & Row, Publishers, Inc., 49 East 33rd St., New York, N. Y. 10016. August 1971. Issued quarterly. Price: $20.00 per year.

Review of Medical Physiology. By William F. Ganong. Published by Lange Medical Publications, Los Altos, California. 1971. 573 pages, Price: $8.50.

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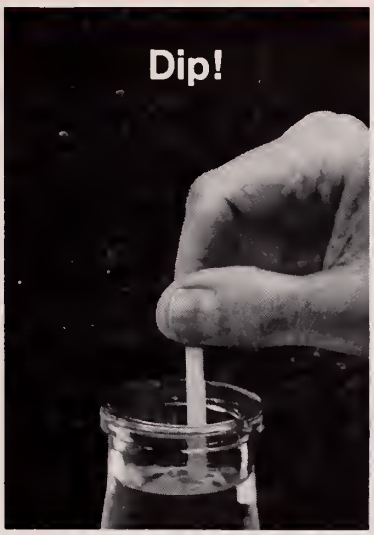

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PRESIDENT'S PAGE

Swan Song

As the time approaches when my term of office will be over, I'm sure it is only natural to review the past year. It has, personally, been a very rewarding year. I have met and made many friends throughout the State and Nation and have been impressed by the dedicated doctors that we have in our State. The entire staff of our State Society has been most helpful and cooperative. Believe me, everyone of them is working for our best interests.

I think the fall meeting of the House of Delegates became a turning point. The House took a realistic look at legislation and presented an attitude of compromise and constructive proposals—far better than a stand of uncompromising opposition.

It also has been a very frustrating year. There are so many things that need to be done, and I'm afraid I have been impatient because they weren't accomplished. The "Doctor of the Week" proposal hasn't gotten off the ground because local doctors won't give up a few days to be at the legislative sessions; at the same time local doctors have been very critical of the State Society's efforts on the legislative scene and especially concerning chiropractors. I have said repeatedly at local medical society meetings that if every doctor in the State would spend 15 minutes a month writing a few letters or calling a few legislators, we could overwhelm them.

PACE (Professional Association for Civic Education) has fallen apart due to the lack of support of doctors, but like Phoenix it shall arise from the ashes and become a guiding political influence in our State. It must, for doctors more than ever now must have a central rallying point and PACE should fulfill this need. Get behind your county PACE chairman and move. Let's keep PACE.

The Governor's "Task Force" soon will be considering and recommending many new ideas on the delivery of health care. It behooves all of us to keep informed and put forth every effort to guide and direct these ideas to insure the highest quality of medical care and preserve the free enterprise practice of medicine.

It has been an honor to be your President this past year. I have earnestly tried to improve the image of medicine and to make organized medicine more responsive to the wishes of all doctors. If I have succeeded in any small measure to help the cause, then I consider my year a success.

G. A. Behnke M.D.

G. A. Behnke, MD

Editorials

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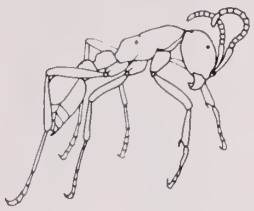
WISCONSIN
MEDICAL JOURNAL

Credibility Gap

A RECENT HARRIS POLL exposed the sad state of public confidence in a number of service professions. In the "great deal of confidence" category these results were reported between 1966 and 1971: Congress fell from 42 percent to 19 percent; the Executive Branch of government fell from 41 to 23 percent; the Supreme Court from 31 to 23 percent; and even educators fell from a lofty 61 percent to a mere 37 percent. Physicians, although described as overworked, overspecialized and overcharging, especially since Medicare and Medicaid, were nonetheless granted a vote of personal confidence by 78 percent of those polled.



It would be too easy to merely say that public opinion rests only on the public's perception of physicians as hard working and truly scientific. A quick review of Lippmann's Public Opinion, or even careful attention to the news media in the past ten years, or listening to our own patients, will suggest that many other factors go into a vote of public confidence. As physicians we can well turn our attention to some of these factors.

One factor that seems pertinent is the undeniable, although often unrecognized, fact that medicine as an institution and medicine as an effective instrument of treatment have coincided at least since the turn of the century. Before that time it was assumed a person's chance of cure was not much above chance, with or without medical help, and little matter what was the matter. The self-discipline of the medical profession following the Flexner report for example, made the profession a generally effective device to produce what cures are available. It had not been particularly effective before that despite the curious fact that it was the dominant institution, at least in our culture, for the treatment of ills. As we know certain countries today, Brazil for example, give equal institutional *and* instrumental weight to various forms of shamanistic practice, and standard medical practice, even among the upper classes. To fail to recognize this somewhat technical distinction could be a dangerous overestimation of our science and our industriousness, and it could leave us vulnerable to sudden social shifts.

This will be dealt with in greater detail in next month's editorial pages, but one clinical vignette will suffice for now. A young woman who expressed real rage at her family physician for not discovering her grandmother's diabetes, which resulted in her unexpected death during a hospital crisis, had this to say: "I really hate him for how he treated my father, too; and his friend, the eye surgeon, had to cut my eye a second time to get the muscles right. But last month I had a severe chest cold and called him anyway. He got me well in two days." When asked how she coordinated these statements, she said simply, "well he knows our family and there was no one else I could go to for help." This was said with neither anger, at this point, nor great admiration either, and leads to the next point about public confidence in doctors.

This second point could be called "access to health delivery systems," and at this we are considerably skilled. Despite need to wait in private offices, and certain complaints about hospital obfuscation and costs, the *means* by which most any complaint of a physical nature can be processed, studied, and often treated is really remarkable. Now this is not strictly a medical skill at all, but more like the merchandizing aspect of any material product. Doctors have really no training in this, save by example, while industrialists can hire a PhD in marketing to move their product or service from here to there. This is fully discreet from scientific medicine, as well as from plain hard work, although some overlapping does exist.

A last point, and certainly not the end of the list but of our space this month, is the subtle recognition by the bulk of persons (maybe 78%) that the physician somehow more fully than all others adopts a life style that lends itself to empathetic focus upon the general needs of the patient. Of course this is neither total, nor always possible, but it could be thought of as a mental "set," in which the physician comprehends, at least after some years of practice, what the painful experience of illness means to a patient. When this happens and real feelings evolve in the doctor, then this sense of caring transmits itself almost at once to all but the most paranoid patients. Once this bond is established, based upon an exchange of feelings about a tough human struggle, it becomes the glue which holds the physician-and-patient institution together. It can hold respect even when inevitable errors are made. Without this bond the smallest error brings rupture of the treating relationship, and sometimes legal suits. Studies have shown, for example, that malpractice charges relate more directly to the interpersonal relationship between patient and doctor than they do to the actual event, even for extreme examples.

There are more factors than these. If a reader can identify others, please send them in and share with your peers. We need to learn how we all work with patients, if we are to survive as a profession, and especially if we must now begin serious and massive peer review systems.—RH

The Specter of Abortion

PHYSICIANS ARE ONLY beginning to be aware of the tumultuous undercurrents that accompany the abortion issue. For most of us the problem was thought to have been settled in a sort of double bind, in which the law was clearly set one way and our feelings set the other. Many simply learned to live with this, not necessarily happily. Now there is ferment about the legal points, new data on physical aspects of abortion, and continued polemics about ethical and personal considerations. Physicians will continue to be square in the center of this controversy and cannot afford to be uninformed of new trends, nor to be unthoughtful as to what position to take. Practically no doctor can remain aloof nor practice without sometime needing to take a stand about abortion. This issue of the *Wisconsin Medical Journal* brings some part of the problem into focus. Not all physicians agree with the items discussed, and not all readers will even agree that this material should be published. Please read what has been accepted for publication in this issue. Then express your opinion as firmly as you care to. Some of the information may surprise you. All of it may be of some use, at least in your thoughtfulness about the issue.—RH

Liberal and Conservative Redefined

THE READER'S SERIOUS ATTENTION is called to a carefully done research report on attitudes toward abortions. Three medical students, Paul Halverson, Gloria Halverson, and Claire Scheele, surveyed over 100 Milwaukee obstetricians and gynecologists and have come up with some dynamic observations, well worth reading and studying. It should be noted that "liberal" and "conservative" are used here not in their general meaning but refer to the issues as stated on their questionnaire regarding "Attitudes Toward Abortion." Some might argue over this use of already established words, but none can argue over

their well documented observations about these particular physicians who are, after all, at the forefront of the abortion issue. Who can really say which is the "liberal" attitude, and toward whom?

Some physicians will be interested in the differences found between Marquette* graduates and non-Marquette graduates, a finding not consistent when Catholic and non-Catholic physicians are studied. Most fascinating is their observation that physicians over 50 years of age are more "liberal" (by their definition of attitudes toward abortion) than those doctors only a few years out of school. Regardless of your personal views on this presently unresolved legal–social–moral issue in American medicine, this paper warrants your attention. As a codicil, your attention is also directed to the Nov. 22, 1971, issue of *JAMA*, page 1173, in which the role of the psychiatrist in abortions is critically reexamined.—RH □

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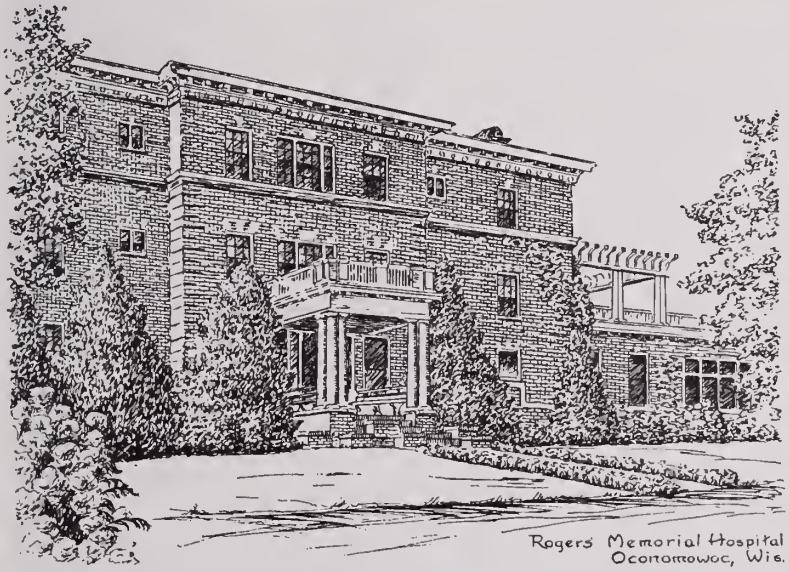

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WISCONSIN MEDICAL JOURNAL
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Medical
GREEN SHEET
NEWS OF SOCIO-ECONOMIC MEDICINE

Resolutions Readied for SMS Annual Meeting

The following resolutions were received in the Secretary's office by April 10. These will go to the State Medical Society's House of Delegates for action at the Annual Meeting beginning May 8 in Milwaukee. Members are urged to express their opinions to their delegates and, if they wish, to participate in the Reference Committee sessions where resolutions are discussed in detail. The Reference Committees will meet in open session at 7:30 p.m., Monday, May 8.

(The county medical society or scientific section that has introduced the resolution appears in parentheses below.)

A. *(Rock)* **Medicare.** Asks that WPS insert a 3″ x 5″ card into each statement to Medicare-eligible patients when reporting charges not fully covered by Title 18, the wording to be as follows:

"NOTE: Medicare, under its present fee schedule, cannot pay the entire amount of those charges labeled 'More Than Medicare Allows.' However, this phrase, 'More Than Medicare Allows,' does not mean that the charges made by your physician are greater than those charges usual and customary for your community.—THE STATE MEDICAL SOCIETY OF WISCONSIN"

B. *(Eau Claire–Dunn–Pepin)* **Professional Fees.** Asks "that the House of Delegates of the State Medical Society of Wisconsin direct a study of the present variation in medical fees for all counties and move promptly to effect a single fee schedule for the State of Wisconsin when the present 'temporary' government controls are ended."

C. *(Waukesha)* **Legislative Activities.** Asks "that this House of Delegates instruct the Council of the State Medical Society to plan an effective approach at both a State and County Society level with communication and coordination between these levels that make for effective impact to both legislative committees and to individual legislators to the end of more cogent and effective legislation bringing to the greatest number of citizens of our state the best and most effective medical care possible."

D. *(Waukesha)* **Redistricting.** Asks "that the President of this Society be instructed to appoint immediately an ad hoc committee to review the present districting of the State Medical Society of Wisconsin with regard to pattern of practice and the presentation of a cohesive unified front within logical areas of medical planning and report such findings and recommendations growing out of these findings to the Society and its officers for implementation." It asks "that the ad hoc committee make its recommendations to the Council within six months following adoption of this resolution so that appropriate action can be taken by the House of Delegates no later than May, 1973."

E. *(Waukesha)* **Annual Scientific Meeting.** Asks "that the President of this Society be instructed to appoint immediately an ad hoc committee to review the alternative advantages and disadvantages to a change in the present meeting procedures of the Society and on the basis of this study to make recommendations to be submitted to the Society and its officers for implementation."

F. *(Barron–Washburn–Sawyer–Burnett)* **Chiropractic.** Asks "that the Commission on Public Policy of the State Medical Society take appropriate action to have introduced into the 1973 session of the Wisconsin Legislature, a bill which would provide that any applicant for the licensure to practice medicine, dentistry, osteopathy, podiatry, optometry, or chiropractic, who is a graduate of a professional school or college of the United States, shall not be eligible for licensure by this state unless said school or college of which he is a graduate has been accredited by an accrediting agency recognized and approved by the National Commission on Accrediting and the United States Office of Education."

G. *(Pierce–St. Croix)* **Phase II.** Asks the Society to challenge discriminatory legislation allowing the medical profession "a maximum of 2½% annual increase in fees" and to "support any individual or group challenging the above-mentioned legislation."

continued on next page

H. *(La Crosse)* **Drunken Driving.** Asks "that the State Medical Society of Wisconsin take a strong stand on drunken driving:

"(1) Those individuals considered to be intoxicated while driving [blood alcohol 0.01%] should automatically have their licenses suspended for six [6] months.

"(2) If convicted a second time, their licenses should be suspended for ten [10] years. At the time of the second conviction the individual will be given the alternative of enrolling in an active Alcoholic Rehabilitation Program rather than the ten-year suspension of driving privileges."

I. *(Outagamie)* **Legislative Activities.** Asks "that the duly appointed chairman of the State Medical Society of Wisconsin's Commission on Public Policy be charged with the responsibility and empowered to insure that each member county medical society is informed of its responsibilities in the legislative arena on those matters affecting the medical profession" and states "that visitation with legislators and at legislative sessions to promote legislative actions vital to the medical profession is the civic duty of all members."

J. *(Dane)* **Membership.** Asks "that the bylaws and constitution of the State Medical Society of Wisconsin be changed to permit a fully accredited physician to become a member of his county medical society and the State Medical Society of Wisconsin without simultaneous membership in the American Medical Association.

K. *(Lafayette)* **Membership.** Requests that the Society "make optional AMA membership for its many individual members; thus membership provisions [revised 1971] should be changed:

"1. *Eligibility*

1.1 . . . .

1.2 . . . .

1.3 The county society is the only portal of entry to membership in the State and national societies. OMIT the remainder of this section.

1.4 Membership in the American Medical Association or the National Medical Association may be requested by State Society members in good standing at the individual member's option."

L. *(Pediatrics)* **First Day Health Insurance Coverage For Infants.** Asks "that the State Medical Society of Wisconsin vigorously supports the eradication of the fourteen day exclusion clause from all health insurance policies sold in the state."

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MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

M. *(Milwaukee)* **Comprehensive Health Planning.** Asks "that the State Medical Society of Wisconsin provide, at an early date, a statewide meeting for physicians participating in local comprehensive health planning agencies."

N. *(Kenosha)* **Mandatory Visits to Extended Care Facilities.** Asks "that the House of Delegates of the State Medical Society of Wisconsin endorse the decision of the American Medical Association that, in the interest of the best patient care, the frequency with which patients are seen is properly the decision and responsibility of the physician, subject to proper and recognized review by his peers;" and further asks "that a copy of this resolution be transmitted to each Wisconsin Senator and Congressman with a request that he take whatever action necessary to attain the earliest possible elimination of the monthly visit rule."

O. *(Juneau)* **Usual and Customary Fees Paid by WPS and Surgical Care.** Asks "that the House of Delegates direct WPS and request Surgical Care to equate the usual and customary fee for all physicians in Wisconsin whether they are located in a rural area or in an urban area."

P. *(Lincoln)* **Payment Criteria of Surgical Care–Blue Shield of Milwaukee County.** Asks "that the State Medical Society of Wisconsin take appropriate legal action against Surgical Care–Blue Shield of Milwaukee County, enjoining them from paying less than the usual, and customary physicians' fees as indicated in their health insurance contracts, or to have their contracts changed to so state that they will not pay the usual and customary fees."

Q. *(Dodge)* **Chiropractic.** Asks "that the State Medical Society of Wisconsin not only reaffirm its opposition to chiropractic, but take positive steps to finance a campaign, with assessment of the membership if necessary, to inform the public and the legislators of chiropractic's threat to good health care of Wisconsin citizens."

R. *(Green)* **Organization and Function of AMA.** Asks "that the State Medical Society of Wisconsin go on record favoring the recommendations of AMA President Wesley Hall regarding reevaluation of the organization and function of the American Medical Association."

S. *(Brown)* **Creation of Age-Exempt Membership Category.** Asks "that an additional section (category) be established of Age-Exempt waiving the State Medical Society dues for licensed, practicing physicians over the age of 70 years, conforming with the AMA Age-Exempt category."

T. *(Trempealeau–Jackson–Buffalo)* **Chiropractic.** Asks "that the State Medical Society of Wisconsin petition the Legislature to pass legislation to outlaw the cult of chiropractic practice within the borders of the State of Wisconsin."

U. *(Trempealeau–Jackson–Buffalo)* **Uniform Fee Schedule.** Asks "that the State Medical Society of Wisconsin move to uniform physician fee sched-

continued on next page

ules on the singular basis of services rendered by licensed physicians and without respect to race, creed, color, or special training." It states "that the establishment of allowable Medicare payments to providers in Wisconsin through Wisconsin Blue Cross and Blue Shield may have involved coercion, intimidation and bureaucratic manipulations and may be illegal." It further asks "that appropriate protest or legal action be lodged once more against this Federal Agency (Medicare) in light of these possibilities and that if successful, suit be brought to recover lost fees as properly established prior to Phase I of the 'Wage–Price Freeze'." It states "that failure of our State Society and the AMA to properly note these resolutions may further fractionate our society."

V. *(Dane)* **1975 Annual Meeting.** Resolves "that the members of the Dane County Medical Society cordially invite the House of Delegates to schedule the Annual Meeting of the Society in Madison for 1975."

Reports Set Direction for Future SMS Committee Work

Reports on the activities of each of the State Medical Society's commissions and committees are submitted every year at the time of the Annual Meeting. These reports include a summary of progress made and many of them contain recommendations for action by the Society. These recommendations will be of interest to all members and are excerpted here from reports received up to the time the GREEN SHEET went to press.

* * *

COMMISSION ON PUBLIC POLICY *recommends* that all State Medical Society Delegates impress on their county societies the imperative need to let Wisconsin's Senators and Representatives know of their interest and medicine's concern for the public health. To implement action by the House of Delegates and President Behnke's suggestion of last October, the Commission encourages physicians to make themselves available for a "Physician of the Week" to be present at the Capitol during the legislative sessions starting in January of 1973 when the Legislature next convenes. Cooperation from individual physicians is the only way to make this program work, the Commission emphasizes.

COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION *recommends* adoption of a resolution asking that "Wisconsin hospitals be encouraged to continue to provide education for nurses at the diploma level, and in instances where this has been discontinued in favor of a licensed practical nurse program or an associate degree program, consideration be given to reinstituting the three-year diploma program."

COMMITTEE ON OCCUPATIONAL HEALTH OF THE COMMISSION ON HEALTH INFORMATION *recommends* the formation of occupational health committees at the county medical society level. These committees would help disseminate appropriate information and act as a source of advice and service to local industry, where needed.

COMMISSION ON SAFE TRANSPORTATION *recommends* to the House of Delegates that it reiterate its support for legislation which would:

(a) upgrade ambulance operations and standards for ambulance personnel;
(b) adopt a .10 level for determination of alcohol impairment for driving;
(c) require the use of seat belts on school buses; and
(d) create an official Medical Advisory Board to the Wisconsin Division of Motor Vehicles.

The Society did support legislation during this session on all of these subjects. However, such legislation did not pass, and it is the opinion of the Commission that the Society must continue to press for passage of such bills if desirable standards of safety are to be implemented in Wisconsin.

DIVISION ON AGING OF THE COMMISSION ON STATE DEPARTMENTS *recommends* that the House of Delegates endorse and encourage the Woman's Auxiliary to strengthen its programs for the elderly. Such programming should be coordinated by the state organization, but because the need for types of services varies geographically, it is recommended that each County Auxiliary clear its plan of action with the County Medical Society with which they will be working.

In addition, the Division *recommends* that the House go on record encouraging property tax relief, based on need, for all Wisconsin senior citizens. Along this line, the Division also *recommends* to county societies that they make every effort to assure that there is physician representation on the many Housing Development Authorities which are now being created throughout Wisconsin.

The Division also *recommends* that during the coming year the Society hold conferences on a regional basis, such as the one on "Special Problems of the Nursing Home Patient" held in Milwaukee last October.

DIVISION ON ALCOHOLISM AND ADDICTION OF THE COMMISSION ON STATE DEPARTMENTS *recommends* that the House of Delegates adopt a position supporting the enactment of the Uniform Controlled Substance Act in Wisconsin as amended during this session of the legislature.

The Division also *recommends* that the Society continue to support legislation which would fund community programs to establish alcoholism and drug abuse treatment centers.

The Division further *recommends* that the Society support the position that if an individual practitioner desires to become involved with methadone mainte-

continued on next page

nance therapy, he should do so through an established program as promulgated by FDA rather than be permitted to do so outside of an approved program.

The Division also *recommends* that the Society not adopt a position at this time on the proposal that all medicines containing codeine be on a prescription basis. A position should not be adopted until it is determined, from a reliable source, the amount of abuse which could be controlled by prescription restrictions in this instance.

The Division *recommends* to the Society that the 1973 Annual Meeting deal with contemporary medical topics such as use of methadone, contemporary treatment of the heroin addict, drug abuse, alcoholism, liability and consent for treatment as well as other problems of current and pragmatic interest to the practitioner.

Annual Meeting Business Schedule

All business meetings including House of Delegates, Reference Committees, Council, Council Committees, and related functions will be held at the HOLIDAY INN CENTRAL in Milwaukee as follows:

Saturday, May 6

5:30 pm	Council Executive Committee Dinner
7:00 pm	Council Executive Committee Meeting

Sunday, May 7

12:00 N	Council Luncheon
2:00 pm	Council Meeting
6:00 pm	Awards Dinner—(50 Year Club and others, Councilors and Officers)

Monday, May 8

10:30 am	Section Delegates Caucus Meeting
1:00 pm	House of Delegates Registration
2:00 pm	House of Delegates First Session (Reports of officers, commissions, and committees, and new business)
5:30 pm	House of Delegates Buffet Supper
7:30 pm	Reference Committee Meetings (Resolutions and Amendments, Reports of Standing Committees, Reports of Officers, and Finance)

Tuesday, May 9

3:00 pm	Nominating Committee
6:00 pm	House of Delegates Registration
7:00 pm	House of Delegates Second Session (Reports of Reference Committees)

Wednesday, May 10

7:30 am	House of Delegates Registration
8:30 am	House of Delegates Third Session (Election of Officers)
10:30 am	Council Meeting
11:30 am	Charitable, Educational and Scientific Foundation Board of Trustees Meeting
12:30 pm	Council and CESF Board of Trustees Luncheon
6:00 pm	President's Reception

Thursday, May 11

12:00 N	Past Presidents Luncheon

DIVISION ON EAR, NOSE AND THROAT OF THE COMMISSION ON STATE DEPARTMENTS *recommends* to the House of Delegates that the physicians of the state be requested to cooperate in hearing conservation programs as required under the new Occupational Noise Exposure Code of the Wisconsin Department of Industry, Labor and Human Relations. It *recommends* that a list of qualified physicians who would be willing to act as industrial consultants be made available to the Department of ILHR.

DIVISION ON SCHOOL HEALTH OF THE COMMISSION ON STATE DEPARTMENTS *recommends* yearly physicial examinations for students participating in interscholastic sports. It *recommends* that a standard form be developed for reporting the basics of the examinations to any agency or organization requesting it and the Division plans to continue its work on such a form.

It *recommends* that the "Days-Out" regulations of the Wisconsin Interscholastic Athletic Association be a part of the playing rules rather than a part of the WIAA insurance benefit structure.

It *recommends* that physicians take note of the policy the Division has approved on administering medications in schools.

DIVISION ON MATERNAL AND CHILD WELFARE OF THE COMMISSION ON STATE DEPARTMENTS *recommends* Wisconsin insurance carriers providing health care benefits be urged to provide coverage for newborn infants effective at birth without waiting periods, or days of exclusion.

The Division *recommends* that hemagglutination tests for rubella be performed at the time of the premarital examination of the female, or on each new obstetrical patient who has not been tested.

It *recommends* caution in the use of hexachlorophene on newborns. The Division supports the statement of the American Academy of Pediatrics in this regard as published in the January, 1972 Newsletter Supplement of the Academy.

DIVISION ON VISION OF THE COMMISSION ON STATE DEPARTMENTS *recommends* that during the 1973 session of the State Legislature the Society again introduce and actively support legislation to require the use of safety glasses in certain academic classes such as industrial arts and chemistry laboratories. For fiscal reasons such a bill failed to pass during the 1971 session.

The Division *recommends* that through formal action by the House of Delegates the Society endorse and lend full support to a Conference on Learning Disabilities to be held at the time of the Wisconsin Education Association meeting next fall. The Division will assist in implementing this conference in cooperation with the Section on Ophthalmology of the Society, the Department of Public Instruction, and the Wisconsin Education Association.

continued on next page

AD HOC COMMITTEE ON SECTION DELEGATE REPRESENTATION *recommends* continuation of voting privileges for specialty representations in the House of Delegates.

AD HOC COMMITTEE ON ANNUAL MEETING *recommends* to the Council:

(1) The scientific program and the House of Delegates should convene at the same time with the House of Delegates meeting before and, if necessary, after the scientific programs.

(2) Separate budgets should be provided for the House of Delegates and the scientific programs.

(3) The scientific programs should be limited to two days and follow the format of the 1972 Meeting for 1973 and 1974. The 1975 Meeting should utilize the facilities of the Sheraton Motor Inn, the Coliseum, and offices of the State Medical Society in Madison.

(4) A $10 educational assessment be added to the dues structure to be effective in 1975 earmarked specifically for postgraduate education.

The educational assessment will replace funds lost by diminishing income from rental of technical exhibit space. It is anticipated technical exhibit rental will be entirely phased out with the 1975 Annual Meeting.

(5) The Bylaws of the State Medical Society be changed to provide the Commission on Scientific Medicine be composed of nine members, three of whom will be elected each year for a three-year term, the tenure of any commissioner to be limited to three consecutive terms.

In addition, the Medical Editor of the *Wisconsin Medical Journal,* the Deans of the University of Wisconsin Medical School and the Medical College of Wisconsin to serve as members ex officio.

(6) The matter of continuing educational programs be referred to a special committee.

(7) The Ad Hoc Committee continue its existence to evaluate the recommendations contained herein.

(8) The Wisconsin specialty societies be asked to appoint a representative to attend meetings of the Commission on Scientific Medicine to effect liaison on a continuing basis.

MD Diabetes Symposium Set, St. Francis, Milwaukee

An all-day physician's symposium on diabetes will be presented Wednesday, May 17, at St. Francis Hospital in Milwaukee.

Entitled "Diabetes Update: Management and Control," the symposium will be concerned with

. . . the reality of treating and managing diabetics,
. . . the use of laser beam treatment in preventing sightlessness,
. . . the correlation between diabetic control and education,
. . . the medical management of diabetics during surgery, and
. . . the "pill," insulin and the diabetic.

Doctors Alexander Marble of the Joslin Clinic and James Mercer Moss of Georgetown University Hospital, and other leading physicians in their field will be lecturing.

The symposium is sponsored by St. Francis Hospital's Diabetic Community Education Center. It has been approved for six elective hours by the American Academy of Family Physicians.

John W. Byrnes: Key Congressional Leader

Influential . . . responsible . . . administration spokesman . . . party loyalist . . . defender of orthodox economic policy. All of these adjectives have been used frequently to describe the speaker at the State Medical Society's public affairs breakfast May 9.

U. S. Representative John W. Byrnes, ranking Republican on the House Ways and Means Committee, has won solid respect throughout the Congress for his leadership in shaping economic policy. It has been said that Congressional respect for Rep. Byrnes is a prime reason why recommendations from Ways and Means are followed so often on the House floor.

In addition, he has been a steadfast friend of medicine, supporting the independence of physicians and the use of voluntary health insurance as the best method of health care financing.

Representative Byrnes, 58, has served in Congress more than half his adult life. He was 27 when he was elected to the Wisconsin Legislature in 1940, the first Republican to represent the Green Bay area in many years.

Four years later, after serving as majority floor leader in the state Legislature, he won a three way race for Congress and has had few election problems since.

He achieved his first formal Congressional leadership position in 1959 when he became chairman of the House Republican Policy Committee. Under his leadership, the policy committee sometimes set official leadership policy before key House votes and issued background papers on legislative issues.

Representative Byrnes was an early advocate of tax and welfare reform and is the co-sponsor of the Tax Reform Act of 1969 and the Family Assistance Act of 1970. In addition to Ways and Means, he is a member of the Joint Committee on Internal Revenue Taxation, the Joint Committee on Reduction of Federal Expenditures, and the House Republican Committee on Committees.

In the Wisconsin Presidential Primary of 1964, Rep. Byrnes was elected Wisconsin's favorite son candidate for the Republican Presidential nomination, a responsibility he had agreed to accept to further party harmony in Wisconsin. He also was named as chairman of the Wisconsin delegation to the 1964 Republican Convention.

In January, Rep. Byrnes announced that he would not be a candidate for reelection this fall. At that time he said that 1973 is an appropriate time to select a new congressman with the formation of a new Congressional District in Northeastern Wisconsin. His retirement from public life comes at the end of 32 years of service in state and national government.

Decision on Contraceptives Puts Wis. Law in Doubt

A United States Supreme Court decision on March 22 may mean that Wisconsin's prohibition on sale of contraceptives to single persons is unconstitutional and unenforceable.

The high court ruled in the Massachusetts case, on a vote of 4 to 3, that single persons have a right to freely obtain contraceptives if the state law also allows married persons to purchase the devices.

The Wisconsin Attorney General's office said, following the decision, that it could take from one to six months for it to issue a formal opinion on the status of Wisconsin's law banning the sale of contraceptives to unmarried persons.

Asst. Atty. Gen. Ward Johnson said that although the two laws appear to be very similar, the U. S. Supreme Court's reasoning in the Massachusetts case raises some questions about the effect of its decision on the Wisconsin law. He noted that physicians, pharmacists, and unmarried persons are still technically bound by the Wisconsin law.

The GREEN SHEET will report future developments on this issue as they occur.

New 18-Year-Old Adulthood Has Medical Implications

When Wisconsin's 18 year olds legally became adults March 23, they acquired some responsibilities that have three important implications for medicine.

One. No one over 18 needs parental consent for treatment.

Two. Parents are no longer responsible for the bills of those over 18. Like other adults, 18 year olds must pay their physician's fees or request their insurer to do so.

Three. Medical Assistance for dependent children now applies only to those under 18. Any existing Medical Assistance cards which would entitle a person 18 to 21 years of age to this aid are no longer effective. Physicians should be cautioned that payment for those between 18 and 21 will probably be refused by the Medicaid or Medical Assistance directors if those individuals only claim to such aid is the status of a dependent child.

Field Trip Slated April 27

Members of the Society's Divisions on Handicapped Children and Ear, Nose, and Throat of the Commission on State Departments will take a field trip April 27 for tours of the Wisconsin School for the Deaf at Delavan and the Wisconsin School for the Visually Handicapped at Janesville.

AMA Long-Range Planning Open Hearings May 10

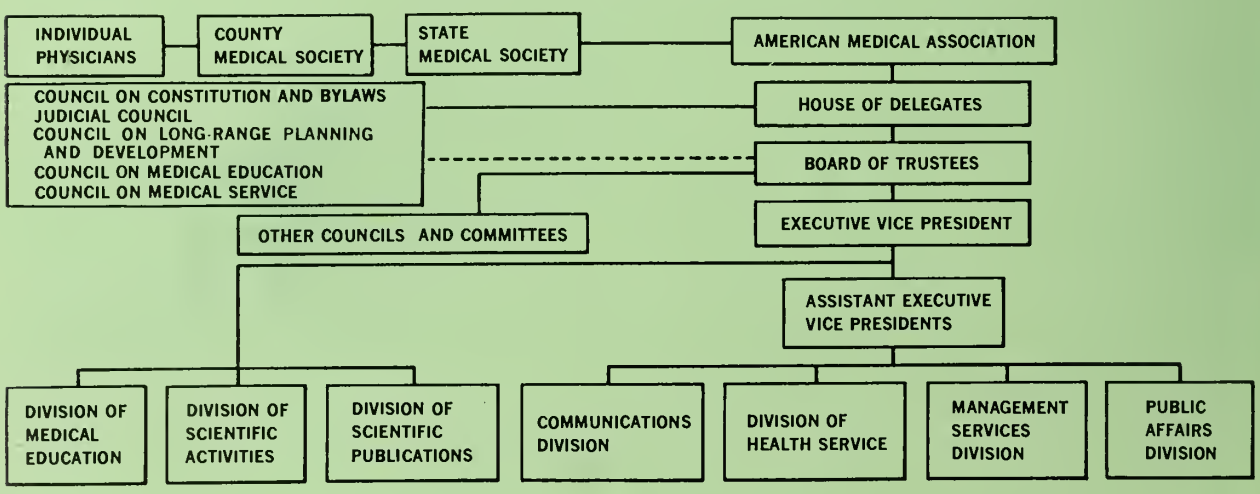
When the American Medical Association was organized in 1847, it set out "to represent the medical community and champion the cause for quality medical care."

How well it has met these goals and what its future role should be will be examined during day-long open hearings Wednesday, May 10, during the State Medical Society's Annual Meeting in Milwaukee. The hearings will be conducted by representatives of the AMA's Council on Long-Range Planning and Development.

Presented below is an organizational chart showing the line of authority starting with the individual physician and extending throughout the Councils and Divisions that make up the AMA. It is presented here to aid those planning to give their views during the open hearings, which will be the first in a series designed to give all AMA members across the country a chance to be heard.

The Wisconsin hearings will be in the French Royal Suite (presidential suite) (24th floor) of Milwaukee's Sheraton–Schroeder Hotel from 9 a.m. until noon, and from 1:30 p.m. until 4:30 p.m. on Wednesday, May 10. The end result of all the hearings, to be held regionally and at this year's AMA annual and clinical conventions, is to be a set of recommendations for presentation at the June 1973 annual convention in New York City.

AMA'S LINE OF AUTHORITY



UW Will Try to "Activate" Town's Health Consumers

The decisions an individual makes about how to take care of himself and when to see a doctor are as crucial to his health as actually being able to get health care when he needs it.

To find out more about the knowledge, attitudes, and behavior of health-care "consumers," the University of Wisconsin Extension has started a project in the small Wisconsin town of Bloomer (population 3,000).

To learn about the health problems of the Bloomer consumer, the University researchers started last month monitoring the local hospital, pharmacy, and physicians' offices to determine what volumes and types of diseases and conditions cause consumers to enter the health-care system. Health consumers also are being telephoned to determine their knowledge, attitudes, and behavior.

The objective of the project is to formulate a consumer health education program that will make the consumer better informed and more aware as measured by personal concern for health, access to health delivery, and knowledge of self-help. It is expected that if the consumer is "activated," the health-care system can then be more effective and efficient.

The education program to be developed will use a broad range of educational methods including: direct personal contact with individuals and groups; mass media (newspapers, radio, television, and telephone/radio network); independent study by means of taped, filmed, and printed material; and such information retrieval systems as the University's telephone dial access library.

Next year at this time another survey will be taken to see if the health education project was successful in educating the community's consumers in the areas which the first survey had identified as problems.

The one-year, $99,395 project is one of four consumer health education studies in the nation approved for funding by the Health Services and Mental Health Administration of the U. S. Public Health Service. It is directed by W. L. Blockstein, PhD, chairman of the University Extension's Health Sciences Unit.

Dr. Blockstein has said: "The University of Wisconsin Extension is pleased to have been selected as one of the four state demonstration projects. These demonstration efforts follow earlier University of Wisconsin research in consumer health education which created a federal decision to fund this project." Dr. Blockstein emphasized that the project should support the consumer health education efforts of the Governor's Health Planning and Policy Task Force.

Hospital Accreditation Workshop Scheduled June 1–2, Wis. Dells

The State Medical Society has joined with the Wisconsin Hospital Association in cosponsoring a one-and-a-half day Workshop on Hospital Accreditation.

The Workshop will be presented by the Joint Commission on Accreditation of Hospitals on Thursday and Friday, June 1 and 2, at the Chula Vista Resort in Wisconsin Dells (10 a.m. Thursday until 12:30 p.m. Friday).

The Workshop will afford participants to become familiar with new accreditation standards with the revised survey procedures and forms, and most important for physicians, a thorough discussion of the new Joint Commission on Accreditation of Hospitals Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations.

Hospital administrators, supervisory personnel, physicians, trustees, attorneys, and others involved in the accreditation process will be interested in attending.

Attendance is limited to 300 persons. A $50 registration fee includes three coffee breaks, two luncheons, one dinner, all materials used and faculty expense.

Registration can be made through the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or the Wisconsin Hospital Association, 5721 Odana Road, P.O. Box 4387, Madison, Wis. 53719.

This announcement is under no circumstances to be construed as an offer to sell or as a solicitation of an offer to buy any of these securities. The offering is made only by the Prospectus.

NEW ISSUE **MARCH 15, 1972**

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SMS committees *in action*

Exercise for the Aging. Division on Aging, March 22, endorsed an initial pilot project for WHA–TV series on "Exercise for the Aging."

Shelter for the Aging. Division on Aging, March 22, agreed to recommend that the House of Delegates go on record encouraging property tax relief, based on need, for all of Wisconsin's senior citizens. It recommended that physicians be encouraged to become members of the various Housing Development Authorities which are now being set up across the state.

Committee on Peer Review. Met March 18 for the first time as a Council committee. It formerly had been the Advisory Committee on Utilization Review Programs of the Commission on Medical Care Plans. Owen E. Miller, MD of Waukesha was elected vice-chairman. Paul B. Mason, MD of Sheboygan is chairman.

Medical Library Service Accepts Collect Calls

The resources of the Wm. S. Middleton Medical Library at the University of Wisconsin are available to all Wisconsin physicians, nurses, paramedical personnel, hospital and medical center officials, public and voluntary health workers, librarians, and interested members of the public who work outside the Milwaukee area. These resources are available through the library's statewide division known as Medical Library Service. Health science personnel in the Milwaukee area are served by the Medical College of Wisconsin Medical–Dental Library.

Wisconsin Medical Library Service users may call collect (608)–262–6524 between 8:30 a.m. and 5:00 p.m., Monday through Friday, for these services:

- Answers to reference questions
- Preparation of bibliographies
- Loan of books and journals
- Photocopying of journal articles
- Information on MEDLARS and MEDLINE computer search services
- Workshops for hospital library personnel
- Consultation for hospital libraries

Medical Library Service personnel cannot provide extensive literature searches, but they can answer general and specific questions and provide recent reviews of literature pertinent to problems of patient care. Requests for materials or information not available at the University of Wisconsin are automatically forwarded to the Medical College of Wisconsin Medical–Dental Library in Milwaukee or the Midwest Regional Medical Library Service located at the John Crerar Library in Chicago.

A maximum of five specific items can be requested from Medical Library Service on the collect line; longer lists must be submitted in writing or on the TWX. The mailing address for Medical Library Service is 1305 Linden Drive, Madison, Wisconsin 53706. The TWX number is 910–286–2778.

If a collect call is likely to be lengthy, the caller may be asked to leave his name, number (including area code), plus a brief description of his problem to the person answering. The appropriate Medical Library Service librarian will then return his call on a less expensive DAIN line.

Further details on all the services can be obtained by contacting Mrs. Ann L. Schaap, Director, Medical Library Service.

300 Persons Attend Farm Accident Symposia, March

Most people don't think of belts and roll-over bars in connection with farm equipment, but it is possible they may become standard on tractors within the next few years.

Allen G. Brailey, Jr, MD, told participants in the State Medical Society's farm accident symposia during March that this protection may be made mandatory by federal law. He said that Sweden, Norway, Finland, and Great Britain now have such requirements.

As part of the program held in Green Bay, Eau Claire, and Madison, Dr. Brailey and Sigurd B. Gundersen, Jr, MD reviewed typical farm accidents that have occurred in Wisconsin. Dr. Gundersen told the audiences, many of them members of local Future Farmers of America chapters, that often farm equipment accidents happen not to the inexperienced person but to those who have the most exposure to the machinery. He said the experienced operator may leave the tractor running or not stop the power take-off on other machinery when correcting some fault—often with disastrous consequences.

"They've had some experience," he said, "but for some reason they take short cuts. By taking extra time the farmer may save himself his arm, his leg, or his life."

Close to 300 people came to the three presentations to hear seven speakers. In addition to Drs. Gundersen and Brailey, the programs featured Glenn S. Pound, Dean and Director of the University of Wisconsin College of Agriculture and Life Sciences, speaking on the "Need for Chemicals in Agriculture." Donald V. Jensen of the UW Department of Agricultural Engineering reported on a study of rural Wisconsin accidents just completed by the University of Wisconsin Extension. The safe handling of pesticides and farm equipment safety were other topics covered. Local area residents formed question and answer panels at the end of each program.

1972

ANNUAL MEETING

State Medical Society of Wisconsin

MILWAUKEE

House of Delegates

MONDAY • TUESDAY • WEDNESDAY

MAY 8-9-10

Holiday Inn Central

FIRST SESSION—MAY 8, 2:00 P.M. SECOND SESSION—MAY 9, 7:00 P.M.
THIRD SESSION—MAY 10, 8:30 A.M.
Delegate registration one hour prior to start of each session

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Scientific Program

Exhibits • Traditional Crafts and Fine Arts Show • fotos/72

TUESDAY • WEDNESDAY • THURSDAY

MAY 9-10-11

Sheraton–Schroeder Hotel
Downtowner Motor Inn • Ramada Inn

TIMETABLE

Annual Meeting: State Medical Society of Wisconsin
Milwaukee, Wisconsin: May 6–May 11, 1972

NOTE: S–S: Sheraton–Schroeder Hotel
H–I: Holiday Inn Central
D: Downtowner Motor Inn
R: Ramada Inn

SATURDAY, MAY 6

p.m.

5:30 Council Executive Committee Dinner (Coach N'Three) H–I
7:00 Council Executive Committee Meeting (Coach N'Three) H–I

SUNDAY, MAY 7

noon

12:00 Council Luncheon (Coach Light Rm.) H–I

p.m.

2:00 Council Meeting (Coach Light Rm.) H–I
2:00 Auxiliary Hospitality Room (Coach N'Four) H–I
4:00 Auxiliary Registration (off Lobby) H–I
6:00 Awards Dinner (Coach Light) H–I (50 Yr. Club; Councilors & Officers)

MONDAY, MAY 8

a.m.

8:00 Installation of exhibits (5th fl. & Empire Room, Lobby Fl.) S–S
8:00 Auxiliary Breakfast (Garden Terrace Rm.) H–I
8:00 Auxiliary Registration (off Lobby) H–I
9:00 Auxiliary Board Meeting (Garden Terrace Rm.) H–I
10:30 Section Delegates Caucus Meeting (Room 301) H–I
11:30 Auxiliary Luncheon (Garden Terrace Rm.) H–I

p.m.

1:00 House of Delegates Registration (Coach Light North) H–I
1:30 Auxiliary Business Meeting (Garden Terrace Rm.) H–I
2:00 House of Delegates, First Session (Coach Light Rm.) H–I
5:30 House of Delegates, Buffet Supper (Carriage Rm.) H–I
6:00 Auxiliary Dinner (Garden Terrace Rm.) H–I
7:30 REFERENCE COMMITTEES:
Resolutions & Amendments (Coach Light East Rm.) H–I
Reports of Standing Committees (Coach N'Three Rm.) H–I
Reports of Officers (Coach Light West Rm.) H–I
Finance (Warrior Rm.) H–I

TUESDAY, MAY 9

a.m.

7:30 PUBLIC AFFAIRS Breakfast (wives invited) (Garden Terrace Rm.) H–I
8:00 Auxiliary Registration (off Lobby) H–I
8:00 Registration (4th fl.) and opening of Exhibits (5th fl. & Empire Rm.–Lobby Fl.) S–S
8:30 Clinic Managers Meeting (Peletier Rm.) D
9:30 Auxiliary Business Meeting (Coach Light East Rm.) H–I
9:00 Scientific Programs:
Plenary Session: "Current Status of Venereal Disease" (Loraine Rm., Lobby Fl.) S–S

noon

12:00 Auxiliary Luncheon (Garden Terrace Rm.) H–I
12:00 Clinic Managers Luncheon (Tiffany Rm.) D

p.m.

12:15 Scientific Luncheons (4th, 5th fls.) S–S; R; D
2:00 Scientific Programs
Plenary Session (Loraine Rm, Lobby Fl.) S–S
Allergy: D

continued

TIMETABLE—*continued*

Pathology (English Rm., 5th fl.) S–S
Neurology (Pere–Marquette Rm., 5th fl.) S–S
Psychiatry (Parlor E, 4th fl.) S–S
2:00 Board of Directors, Wisconsin Academy of Family Physicians Meeting (Coach Light East Rm.) H–I
3:00 Nominating Committee (Warrior Rm.) H–I
6:00 House of Delegates Registration (Coach Light North) H–I
6:00 Radiology Dinner: Milwaukee Athletic Club
7:00 House of Delegates, Second Session (Coach Light Rm.) H–I

WEDNESDAY, MAY 10

a.m.

7:15 "The Dying Patient" Panel—Breakfast (Pere–Marquette Rm., 5th fl.) S–S
7:30 House of Delegates Registration (Coach Light North) H–I
8:30 Registration (4th fl.) and Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
8:30 Clinic Managers Meeting (Peletier Rm.) D
8:30 House of Delegates, Third Session (Coach Light Rm.) H–I
9:00 All day special Reference Committee meeting re: AMA Long-Range Planning (French Royal Suite—24th fl.) S–S
9:00 Scientific Programs:
Plenary Session: "Infectious Disease Problems of Increasing Importance" (Loraine Rm., Lobby Fl.) S–S
10:30 Council Meeting (Garden Terrace Rm.) H–I
11:30 Board of Trustees, Charitable, Educational & Scientific Foundation Meeting (Garden Terrace Rm.) H–I

p.m.

12:15 Scientific Luncheons (4th & 5th fls.) S–S; D
12:30 Council and Board of Trustees, CESF, Luncheon (Coach N'Four) H–I
2:00 Scientific Programs:
Plenary (Loraine Rm., Lobby Fl.) S–S
Dermatology (Pere–Marquette Rm., 5th fl.) S–S
Plastic Surgery (Clipper Rm.) D
Public Health (Parlor F, 4th fl.) S–S
6:00 President's Reception (Garden Terrace Rm.) H–I
6:00 Wisconsin Society of Plastic Surgery: Wisconsin Club
8:00 Marquette Alumni Dinner (Coach Light Rm.) H–I

THURSDAY, MAY 11

a.m.

8:30 Registration (4th fl.) and Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
9:00 Wet Clinc (Surgery) St. Joseph's Hospital, Milwaukee
10:00 Wet Clinic (Otolaryngology) V. A. Hospital, Wood
9:00 Scientific Programs
Drug Program (Loraine Rm., Lobby Fl.) S–S
10:30 Resident–Intern Papers Program (Loraine Rm., Lobby Fl.) S–S

noon

12:00 Past Presidents Luncheon (Coach N'Four Rm.) H–I
12:00 Section on Ophthalmology Business Luncheon (Pere–Marquette Rm., 5th fl.) S–S

p.m.

12:15 Scientific Luncheons (5th fl.) S–S; D
2:00 Scientific Programs
Anesthesia (Clipper Rm.) D
Ophthalmology (Pere–Marquette Rm., 5th fl.) S–S
Orthopedics (Peletier Rm.) D
Otolaryngology (English Rm., 5th fl.) S–S
Physical Medicine & Rehabilitation (Parlor A, 4th fl.) S–S
Surgery (Loraine Rm., Lobby Fl.) S–S
3:45 Closing of Exhibits (5th fl. & Empire Rm., Lobby Fl.) S–S
5:30 Wisconsin Orthopedic Society: Milw. Yacht Club
6:00 Milwaukee Ophthalmological Society: Univ. Club
6:30 Wisconsin Surgical Society: Milw. Athletic Club

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

BYRON J. BAILEY, MD, Wiess Professor and Chairman, Department of Otolaryngology, University of Texas, Galveston, Tex.

THURSDAY, MAY 11: 2:20 pm—*Management of Maxillofacial Injuries*

RICHARD H. EGDAHL, MD, Professor and Chairman, Department of Surgery, Boston University Medical Center, Boston, Mass.

THURSDAY, MAY 11: 2:30 pm—*Diagnosis and Treatment of Hyperparathyroidism*

LEE T. FORD, MD, Assistant Professor of Clinical Orthopaedic Surgery, Washington University, St. Louis, Mo.

THURSDAY, MAY 11: 2:00 pm—*Use of Chymopapain in Lumbar Disc Lesions;* 12:15 pm—*Examination of Patient with Low Back and Sciatic Pain*

J. K. FRENKEL, MD, PhD, Professor of Pathology, University of Kansas Medical Center, Kansas City, Kan.

TUESDAY, MAY 9: 1:45 pm—*Topless Toxoplasma—Bottomless Problems of Toxoplasmosis*

HERBERT E. KAUFMAN, MD, Professor of Ophthalmology and Pharmacology; Chairman, Department of Ophthalmology, College of Medicine, University of Florida, Gainesville, Fla.

THURSDAY, MAY 11: 1:30 pm—*Current Concepts in Management of Herpetic Infections;* evening dinner speaker—*Medical and Surgical Treatment of Corneal Disease*

CHARLES H. KIRKPATRICK, MD, Head, Section of Allergy and Hypersensitivity, Laboratory of Clinical Investigation, NIH, Bethesda, Md.

TUESDAY, MAY 9: 3:30 pm—*Deficiency of Cell Mediated Immunity;* 12:15 pm—*Current Intramural Programs of the National Institutes of Allergy and Infectious Disease*

EDWARD LOWENSTEIN, MD, Anesthetist, Massachusetts General Hospital, Boston, Mass.

THURSDAY, MAY 11: 3:00 pm—*Anesthetic Considerations in Coronary Artery Disease;* 12:15 pm—*Autologous Blood Retransfusion Following Extracorporeal Bypass in the Cardiac Surgery Patient*

PETER J. LYNCH, MD, Associate Professor of Dermatology, University of Michigan School of Medicine, Ann Arbor, Mich.

WEDNESDAY, MAY 10: 3:00 pm—*Host—Microbial Interactions from a Dermatological Viewpoint;* 12:15 pm—*Problems in Dermatologic Diagnosis and Therapy*

H. HOUSTON MERRITT, MD, Professor Emeritus of Neurology and Dean Emeritus, Faculty of Medicine, Columbia University College of Physicians and Surgeons, New York City

TUESDAY, MAY 9: 3:30 pm—*Neurosyphilis: A Review and a Look to the Future;* 12:15 pm—*Neurology—Past and Future*

ARNOLD L. SCHROETER, MD, Consultant, Department of Dermatology, Mayo Clinic, Rochester, Minn.

TUESDAY, MAY 9: 9:00 am—*Epidemiology and Treatment of Gonorrhea*

G. KEITH STILLWELL, MD, Associate Professor of Clinical Physical Medicine and Rehabilitation, Mayo Graduate School of Medicine, Rochester, Minn.

THURSDAY, MAY 11: 2:00 pm—*Role of Physical Medicine in Management of Osteoarthritis*

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

JOSEPH P. WHALEN, MD, Professor of Radiology, The New York Hospital–Cornell Medical Center, New York City

THURSDAY, MAY 11: Evening dinner speaker—*Radiographic Approach to Abdominal Masses;* 12:15 pm—*The Role of the Radiology Assistant*

HARVEY A. ZAREM, MD, Associate Professor of Surgery; Head, Section of Plastic Surgery, University of Chicago, Chicago, Ill.

WEDNESDAY, MAY 10: 1:15 pm—*Breast Reconstruction;* 3:00 pm—*Use of Pedicle Flaps for Reconstruction in Cancer Surgery of the Head and Neck*

STATE MEDICAL SOCIETY OF WISCONSIN

Business Schedule

NOTE: *All business meetings* including House of Delegates, Reference Committees, Council, Council Committees, and related functions will be held at the *Holiday Inn Central* in Milwaukee

SATURDAY, MAY 6

Executive Committee of the Council
Dinner and Meeting

SUNDAY, MAY 7

Council Luncheon and Meeting
Awards Dinner—50 Year Club and others
Councilors and Officers

MONDAY, MAY 8

Section Delegates Caucus Meeting
First Session of the House of Delegates
Reports of officers, commissions, and committees, and new business
House of Delegates Buffet Supper
Reference Committees

TUESDAY, MAY 9

Nominating Committee
Second Session of the House of Delegates
Reports of Reference Committees

WEDNESDAY, MAY 10

Third Session of the House of Delegates
Election of officers
Council Meeting
Charitable, Educational and Scientific Foundation Board of Trustees Meeting
Council and CESF Board of Trustees Luncheon
President's Reception

See the TIMETABLE for details on time and room locations

Scientific Program

Sheraton–Schroeder Hotel

TUESDAY, MAY 9

PLENARY SESSION—Morning

Current Status of Venereal Disease

LECTURERS—Arnold L. Schroeter, MD, Rochester, Minn.
Douglas O. Clark, MD, Milwaukee
Gerald J. Dorff, MD, Milwaukee
Walter E. Gager, MD, Milwaukee
J. M. B. Bloodworth, Jr., MD, Madison
Alden W. Dudley, Jr., MD, Madison

SCIENTIFIC LUNCHEONS

Plenary/Allergy/Neurology/Pathology/Psychiatry/Radiology

PLENARY SESSION—Afternoon

LECTURERS—Edwin L. Overholt, MD, La Crosse
Arnold L. Schroeter, MD, Rochester
Michael W. Rytel, MD, Milwaukee
June Osborn, MD, Madison

ALLERGY—Afternoon

LECTURERS—Richard Hong, MD, Madison
Charles H. Kirkpatrick, MD, Bethesda, Md.

NEUROLOGY—Afternoon

LECTURERS—Stanley D. Johnson, MD, Milwaukee
Timothy K. Henke, MD, La Crosse
Henry A. Peters, MD, Madison
Paul L. Schraeder, MD, Madison
H. Houston Merritt, MD, New York City
June Osborn, MD, Madison
Gabriele M. Zu Rhein, MD, Madison

PSYCHIATRY—Afternoon

LECTURERS—Keith M. Keane, MD, Appleton
William H. Heywood, MD, Marshfield

PUBLIC AFFAIRS Breakfast

Tuesday, May 9—7:30 AM

The Hon. John W. Byrnes
REPRESENTATIVE FROM 8TH CONGRESSIONAL DISTRICT

Garden Terrace Room/Holiday Inn Central
(wives included)

WEDNESDAY, MAY 10

PLENARY SESSION—Morning

Infectious Disease Problems of Increasing Importance

LECTURERS—William W. Stead, MD, Milwaukee
Michael W. Rytel, MD, Milwaukee
Charles E. Reed, MD, Madison
Harold D. Rose, MD, Milwaukee
Edwin L. Overholt, MD, La Crosse
Andre J. Lebrun, MD, DPH, DTM, Milwaukee

SCIENTIFIC LUNCHEONS

Plenary/Dermatology/Plastic Surgery/Public Health/Surgery

PLENARY SESSION—Afternoon

LECTURERS—Hugh L. Moffet, MD, Madison
Donn J. D'Alessio, MD, Madison
J. Donald Coonrod, MD, Milwaukee
Gerard T. Scanlon, MD, Milwaukee

DERMATOLOGY—Afternoon

LECTURERS—Sharon D. Lantis, MD, Madison
Hubert V. Moss, MD, Madison
Stephen B. Webster, MD, La Crosse
Thomas J. Russell, MD, Milwaukee
Peter J. Lynch, MD, Ann Arbor, Mich.

PLASTIC SURGERY—Afternoon

LECTURERS—Jerome J. DeCosse, PhD, MD, Milwaukee
Sidney K. Wynn, MD, Milwaukee
John E. Hamacher, MD, Madison
Paul Natvig, MD, Milwaukee
William H. Frackelton, MD, Milwaukee
Harvey A. Zarem, MD, Chicago

PUBLIC HEALTH—Afternoon

A Two-Hour Program

(NO Annual Dinner)

PRESIDENT'S RECEPTION

Wednesday, May 10

6 to 8 PM

Garden Terrace Room/Holiday Inn Central

Everyone attending the Annual Meeting is invited to join President George A. Behnke in welcoming the new President, Dr. Robert F. Purtell, and his wife, at an informal reception.

FRUIT PUNCH HORS D'OEUVRES

Steve Swedish Music

THURSDAY, MAY 11

DRUG PROGRAM—Morning

Highlights of the Pharmacologic Essentials in Clinical Practice

LECTURERS—George E. Whalen, MD, Milwaukee
Paul S. Rosenfeld, MD, Milwaukee
Theodore L. Goodfriend, MD, Madison
Richard I. H. Wang, PhD, MD, Milwaukee

RESIDENT–INTERN PAPERS —Morning

OTOLARYNGOLOGY—Morning

Wet Clinic

SURGERY—Morning

Wet Clinic

LECTURERS—James M. Kenney, MD
William B. Kelley, MD
A. Thiru, MD
Sadao Kasai, MD
John C. Bishop, MD
Robert A. Haushalter, MD
Robert J. Beckes, MD

SCIENTIFIC LUNCHEONS

Anesthesia/Otolaryngology/Orthopedics

ANESTHESIA—Afternoon

LECTURERS—S. Craighead Alexander, MD, Madison
Edward Lowenstein, MD, Boston, Mass.
Donald R. Kahn, MD, Madison

OPHTHALMOLOGY—Afternoon

LECTURERS—Herbert E. Kaufman, MD, Gainesville, Fla.
Harry A. Easom, MD, Milwaukee
Guillermo de Venecia, MD, Madison

ORTHOPEDICS—Afternoon

LECTURERS—Lee T. Ford, MD, St. Louis, Mo.
Donald R. Gore, MD, Sheboygan
Henry I. Okagaki, MD, Madison
Peter B. Salamon, MD, Madison
John M. Jurist, PhD, Madison
Karl H. Mueller, MD, Milwaukee

OTOLARYNGOLOGY—Afternoon

LECTURERS—Mark L. Satz, MD, Madison
Alexander Locke, Jr., MD, Milwaukee
Byron J. Bailey, MD, Galveston, Tex.

THURSDAY *continued*

PHYSICAL MEDICINE AND REHABILITATION—Afternoon

LECTURERS—G. Keith Stillwell, MD, Rochester, Minn.
Robert C. Zuege, MD, Milwaukee
Gerson C. Bernhard, MD, Milwaukee
Edwin C. Welsh, MD, Milwaukee

SURGERY—Afternoon

LECTURERS—Sanford Mackman, MD, Madison
Stuart D. Wilson, MD, Milwaukee
Alfred E. Kritter, MD, Waukesha
Richard H. Egdahl, MD, Boston, Mass.
George M. Kroncke, MD, FACS, Madison
William O. Myers, MD, Marshfield
W. Dudley Johnson, MD, Milwaukee
Derward Lepley, Jr., MD, Milwaukee

President's Address—

Wayne J. Boulanger, MD, Milwaukee

SPECIAL REFERENCE COMMITTEE MEETING RE:

AMA Long-Range Planning

ALL DAY WEDNESDAY, MAY 10

All physicians are welcome to attend and express their views on proposed AMA constitutional convention by President Wesley Hall, MD. SMS Delegates to the AMA and representatives of the Long-Range Planning Committee of the AMA will be present to meet with physicians and solicit their opinions.

Special Annual Meeting Features!

TRADITIONAL CRAFTS AND FINE ARTS SHOW

Ceramics, Drawings and Graphic Arts, Paintings (acrylic, oil, watercolor), Photography, Sculpture, and Three Dimensional Design (crewel, needlepoint, macrame, metalwork, lapidary, pottery, weaving and textiles, woodwork).

Sponsored by the Woman's Auxiliary to the State Medical Society of Wisconsin

fotos/72

PHOTOGRAPHY CONTEST

Beautiful and exciting pictures taken by physicians. Featuring medicine, travel, people, animals, and general pictorial scenes.

ON DISPLAY IN THE EAST ROOM, SHERATON–SCHROEDER HOTEL

The Dying Patient

A FRANK PANEL DISCUSSION FOLLOWING

BREAKFAST

WEDNESDAY, MAY 10
7:15 A.M.

Pere–Marquette Room
Sheraton–Schroeder Hotel

Introduction by *J. O. Simenstad, MD,* Osceola
Chairman, SMS Committee on
Medicine and Religion

PANELISTS

John E. Dooley, MD, Milwaukee
(MODERATOR)
Department of Internal Medicine, St. Joseph's Hospital, Milwaukee

Rabbi Michael Twerski, Milwaukee
Congregation Beth Jehudah Orthodox

Reverend Patrick J. Kenny
Member of the Order of St. Camillus
Chaplain at St. Joseph's Hospital, Milwaukee

Reverend Lowell H. Mays
Professor of Medical Ethics
University of Wisconsin Medical School

Every physician faces the problem of dealing with the terminal patient. This panel of experienced men will make it worthwhile for you to attend—and take part in the discussion.

Co-sponsored by the Catholic Physicians Guild and the SMS Committee on Medicine and Religion.

Wisconsin Clinic Managers

CONVENTION

Tuesday, May 9–Wednesday, May 10

Downtowner Motor Inn

Luncheon—Tuesday, May 9

Marquette Medical Alumni Association

DINNER

Wednesday, May 10—8:00 PM

Coach Light Room/Holiday Inn Central

(following President's Reception)

Tickets for the meeting, which is open to Marquette Medical School graduates, their wives and guests, may be purchased from the alumni office at the medical school or from the desk in the registration area near the meeting room.

EVENING DINNERS

Wisconsin Radiological Society

(members only)

TUESDAY, MAY 9/MILWAUKEE ATHLETIC CLUB
6:00 P.M.

Speaker: *Joseph P. Whalen, MD,* New York City
Professor of Radiology, The New York Hospital—Cornell Medical Center

Topic: *A Radiographic Approach to Abdominal Masses*

Wisconsin Society of Plastic Surgery

(wives invited)

WEDNESDAY, MAY 10/WISCONSIN CLUB
6:00 P.M.

Wisconsin Orthopedic Society

(members only)

THURSDAY, MAY 11/MILWAUKEE YACHT CLUB
5:30 P.M.

Chairman: *Sion C. Rogers, MD,* Madison

Speaker: *Lee T. Ford, MD,* St. Louis, Mo.
Assistant Professor of Clinical Orthopaedic Surgery, Washington University

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Milwaukee Ophthalmological Society

(all ophthalmologists and interested physicians welcome)

THURSDAY, MAY 11/UNIVERSITY CLUB
6:00 P.M.

Chairman: *Howard W. Fiedler, MD,* Milwaukee

Speaker: *Herbert E. Kaufman, MD,* Gainesville, Fla.
Professor of Ophthalmology & Pharmacology; Chairman, Department of Ophthalmology, College of Medicine, University of Florida

Topic: *The Medical and Surgical Treatment of Corneal Disease*

Wisconsin Surgical Society

THURSDAY, MAY 11/6:30 P.M.
MILWAUKEE ATHLETIC CLUB

Chairman: *Ben R. Lawton, MD,* Marshfield

NEWS HIGHLIGHTS

Dr. Curreri Named to Health Sciences Post

Anthony R. Curreri, MD,* chairman of the Department of Surgery at the University of Wisconsin since 1968, has been named assistant vice-chancellor for health sciences at the university in Madison.

UW–Madison vice chancellor Irving Shain said the newly created position will have "wide-ranging responsibilities for coordination of development of the new Center for Health Sciences" in the west campus area. "This will include program review and development, and liaison with state and federal agencies involved in the new construction project."

Dr. Curreri

Doctor Curreri will relinquish his surgery department chairmanship to devote full time to the new position. He will continue clinical teaching and practice as professor of surgery.

Madison chancellor Edwin Young said the appointment fills an important leadership position in the Center for Health Sciences. A search is continuing for a vice-chancellor for health sciences, also a new position.

Doctor Curreri, a 1933 graduate of the UW Medical School, also has served as director of the UW's division of clinical oncology since its creation in 1963.

His contributions to cancer research and teaching have included service on numerous national medical advisory councils. In 1970 he received the Shahbanou award of the Lila Motley Cancer Foundation.

American College of Physicians

. . . recently granted membership to the following Wisconsin MDs: David Sulman, Madison; Nicholas F. Geimer* and Frank A. Walker,* Milwaukee; John P. Konsek,* Neenah; and Marvin G. Parker,* Racine.

Campaign to Recruit Kidney Donors

. . . started March 11 when some 250 persons who have medical, emotional, or personal involvement with kidney disease met for a "Gift of Life" program in Milwaukee. Spokesmen for the Wisconsin Kidney Foundation have stated that about 115 Wisconsin residents could benefit from kidney transplants if the organs were available. As a result of the "pep rally" program, several thousand men and women soon will be taking part in a door-to-door campaign asking people to direct that parts of their bodies be made available after death to relieve the suffering of others. Under the Uniform Anatomical Gift Act, persons may sign a wallet size card before two witnesses. A legal document, it specifies that the signer offers either specified parts or all of his body for medical use after death. *Details of anatomical donor giving, showing a sample card, appeared in the January 1972 Blue Book issue of the* WISCONSIN MEDICAL JOURNAL.

American Academy of Radiology

. . . at its 49th annual meeting in Miami Beach April 4–8, gave certificates of fellowship to the following Wisconsin physicians: Andrew B. Crummy, Jr.,* Madison; Charles E. Schmidt, Milwaukee, and Robert G. Zach,* Monroe.

PHYSICIAN BRIEFS

Peter L. Eichman, MD*

. . . former dean of the University of Wisconsin Medical School, Madison, has been granted leave by the UW to serve as deputy director of the Federal Bureau of Health Manpower Education. The bureau is a component of the U. S. Health, Education, and Welfare Department's National Institutes of Health, Bethesda, Md. Doctor Eichman leaves this month for his new duties. He had been coordinator of health affairs on President Weaver's staff. The Bureau of Health Manpower Education, whose mission is increasing the nation's health manpower pool, is primarily a fund-raising agency with a budget for fiscal 1972 of $650-million. It provides funding for institutional support, medical school expansion and development, and student aid.

James F. McIntosh, MD*

. . . has been named chief of staff of Madison General Hospital in Madison. Other new officers elected by the medical staff include MDs C. Robert Jackson,* vice-chief of staff; Edward H. Kolner,* secretary–treasurer; and Glen J. Stuesser,* trustee to the Dane County Medical Society. New section chiefs are: MDs Darwin D. Waters,* anesthesia; J. Kent Tweeten,* family practice; Donald O. Price,* obstetrics–gynecology; Marvin M. Zolot,* internal medicine; Charles L. Jahn,* pediatrics; Rudolph W. Link,* psychiatry; and Edward Boldon,* surgery.

Richard F. Mattingly, MD*

. . . professor and chairman of obstetrics and gynecology, Medical College of Wisconsin, Milwaukee, has been named editor in chief of *Obstetrics and Gynecology*, the journal of the American College of Obstetricians and Gynecologists. His appointment was effective January 1.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Adolf L. Gundersen, MD*

. . . La Crosse, has been reelected president of the Gundersen Clinic board. MDs Edward L. Perry* and Douglas G. Tompkins* are vice-president and secretary, respectively. New board members include MDs Robert B. Rasmus,* Robert W. Ramlow, William A. Morgan,* Sigurd B. Gundersen, Jr.* Kermit L. Newcomer,* and Anton L. Haidinyak.*

Daniel Schroeder, Jr., MD*

. . . Amery, recently was awarded the Physician's Recognition Award for 1971 by the American Medical Association.

Marvin Wright, MD*

. . . has been named chief of staff of St. Mary's Hospital in Rhinelander. He succeeds Warner S. Bump, MD,* who had held that position for 16 years, having served the Wisconsin northwoods area residents for more than 40 years. Doctor Wright has been practicing in Rhinelander since 1939 and joined the Bump Medical Group in 1942. Others who will serve with Doctor Wright as officers of the medical staff are I. E. Schiek, MD,* as vice-president and John F. Brown, MD.*

William P. Curran, MD*

. . . will be returning to Antigo this month after spending some time in Florida. Before returning, Doctor Curran was to attend the Sixth Annual AMA Congress on the Socio-Economics of Health Care in Fort Lauderdale, April 6–8.

C. Norman Shealy, MD*

. . . La Crosse, on April 26–27 was to participate in an international symposium on analgesics to be conducted at The Cornell University Medical College, New York. His topic was "Non-Pharmaceutical Modes of Analgesia." Doctor Shealy is director of the Pain Rehabilitation Center in La Crosse.

William A. Pruett, MD*

. . . Beloit, recently was named president of the medical staff of Beloit Hospital. Other MDs elected were A. O. Tuftee,* president-elect and D. B. Pili,* secretary-treasurer.

PHYSICIAN BRIEFS/NEWS HIGHLIGHTS

Wisconsin Psychiatric Association

. . . at its February 25–26 meeting in Madison elected the following officers: president-elect—Richard J. Thurrell, MD,* Madison; secretary—Donald T. Fullerton, MD, Marshfield; treasurer—William J. Crowley, MD,* Wauwatosa; councilors—Patricia E. McIllece, MD, Madison, and A. L. Haidinyak, MD,* La Crosse; parliamentarian—Kenneth H. Rusch, MD,* Madison. Doctors Fullerton and Crowley were reelected. All take office effective in May at the time of the APA Annual Meeting. At that time, Raymond Headlee, MD,* Elm Grove, advances from president-elect to president.

Conference on Death and Dying

. . . will be conducted at the University of Wisconsin–Eau Claire, April 27–29, by Dr. Elizabeth Kubler–Ross, author of *On Death and Dying*. The conference is designed for nurses, physicians, clergymen, and other professional persons interested in exploring the reactions, problems, and therapeutic management related to the dying. To register, contact the School of Nursing, University of Wisconsin, Eau Claire, WI 54701. Registration fee: $20.

Gundersen Clinic and La Crosse Lutheran Hospital

. . . following a recent inspection visit, had their Joint Tumor Board and Registry again accredited for three years by the American College of Surgeons. This Registry was initiated in January 1963, largely through the efforts of Robert Ramlow, MD* of the Gundersen Clinic, who was the first chairman of the Tumor Board. Two hundred and eighty-four tumor cases were registered that first year. Since then, 3069 more cases have been registered, and in 1971 almost 600 new cases were entered, the Clinic and Hospital officials reported.

Southeastern Wisconsin Sickle Cell Center

. . . at Deaconess Hospital, Milwaukee, since the Center opened last September, has screened a total of 4,173 individuals at three community locations, in the hospital's outpatient department, and through several cooperating community agencies. Of those, 377 were identified with trait and 14 had sickle cell anemia, variant or other more rare forms of the disease. Figures are identical to estimated national averages of the incidence of sickle cell in the U. S. black population, according to Mrs. Hazel B. Maxwell, the Center's general chairman.

Medical College of Wisconsin

. . . on February 1 acquired a new director of libraries. He is Richard Eimas who had been associate professor of medical administration and director of the medical center library at Vanderbilt University, Nashville, Tenn. The MCW Library now has a collection of 89,000 bound volumes and subscribes to almost 2,000 biomedical periodicals. It has a staff of 16 and provides access to literature in the fields of medicine, dentistry, allied health, and the basic sciences for people throughout the southeastern Wisconsin region.

Tomah VA Hospital

. . . recently added five physicians to its medical staff: MDs Thomas Treiber from Omaha, Neb.; Helen Halbert,* La Crosse; Peter O'Loughlin,* Eugene Traynor, and Joseph Majewski,* Milwaukee.

Harry Ageloff, MD*

. . . Racine, has been elected president of the Racine Council on Alcoholism. He was one of the original staff physicians at the Racine A-Center.

Christopher R. Dix, MD*

. . . Elm Grove, was reelected as chief of staff for Lutheran Hospital of Milwaukee, Inc. MDs William P. Wendt,* Elm Grove, and R. Parks LeTellier,* Wauwatosa, were elected vice-chief of staff and chairman of medicine, respectively.

Renato T. Faylona, MD

. . . Milwaukee, joined the staff of the Dells Clinic, Wisconsin Dells, April 1. A graduate of the University of Santo Tomas Medical School in 1961, he served his internship at Deaconess Hospital, Milwaukee, and his residency at St. Joseph's Hospital, Milwaukee. Prior to his arrival at the Dells, he had practiced at St. Joseph's Hospital.

Walter R. Sundstrom, MD*

. . . Madison, has been named medical director of Reliable Life & Casualty Company, a Madison-based insurance firm. He also has been elected to the board of directors of the insurance company and its parent, Reliable Investors Corporation. Doctor Sundstrom is associated with the East Madison Clinic, is director of medicine at St. Mary's Hospital Medical Center, and serves as assistant clinical professor of medicine at the University of Wisconsin. He is on the board of the Madison Area Health Planning Council and of the Dane County Arthritis Foundation.

James J. Balistrieri, MD*

. . . discussed the "Emotional Aspects of Diabetes" at the March 18 meeting of the St. Mary's Diabetes Group held at St. Mary's Hospital in Milwaukee. Established in October 1971, the St. Mary's Diabetes Group is a chapter of the Wisconsin Diabetes Association. The St. Mary's Chapter serves the diabetic by featuring self-care classes, monthly programs, group discussions, and visits to new diabetics.

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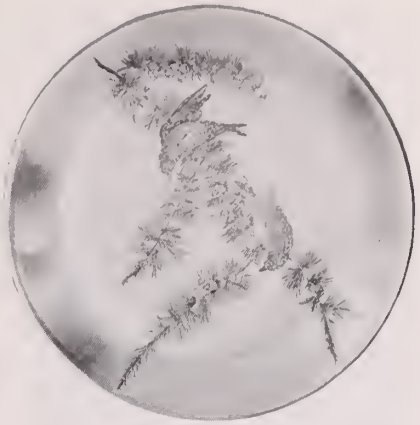

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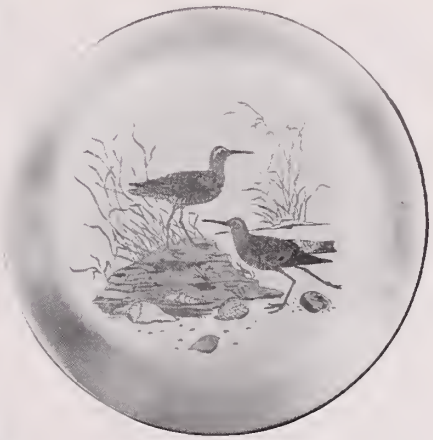

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Dr. Bear and Mr. Bloom

Nathan E. Bear, MD*

. . . Monroe, one of the founders of The Monroe Clinic, is shown above at left accepting a plaque from the president of the Monroe Jaycees, Wilson Bloom, as "outstanding senior citizen" for his civic accomplishments and past achievements.

Carl Zenz, MD*

. . . medical director of the Allis–Chalmers Corporation, has been elected vice-president of the American Academy of Occupational Medicine at the organization's annual meeting held in February in Pittsburgh. Previously, Doctor Zenz had been a director of the organization for three years and chairman of its educational committee. The Academy has approximately 500 members who are associated with various industries, governmental agencies, universities, and corresponding members throughout the world. He is a clinical professor of preventive medicine at the Medical College of Wisconsin and a member of the State Medical Society's Committee on Occupational Health of the Commission on Health Information.

John G. Beck, MD*
H. D. Grota, MD*

. . . veteran members of the medical staff of Door County Memorial Hospital Corp., were honored at the hospital's 25th anniversary celebration in February. Doctor Grota has been practicing in Sturgeon Bay since 1936 and Doctor Beck, since 1942. Both received gifts from the hospital.

PHYSICIAN BRIEFS/NEWS HIGHLIGHTS

Skemp–Grandview Clinic

. . . in La Crosse is constructing a $500,000 addition to its building, according to Julius Wetsch, clinic administrator. Completion is scheduled in August or September. The addition will be a three-story, 16,800-square-foot building and will provide space for an additional 11 doctors, Mr. Wetsch said. The medical facility is located near St. Francis Hospital.

The Sheboygan Clinic

. . . recently announced the election of officers of its organization for the calendar year 1972. Elected to the executive committee were MDs E. G. Schott,* president; R. M. Senty,* vice-president; R. B. Windsor,* secretary; R. A. Wood,* treasurer; and E. H. Jochimsen,* member. Directors and officers elected to the Clinic Building Company, a separate holding corporation, were MDs R. A. Wood,* president; R. M. Senty,* vice-president; and P. A. Sciarra,* secretary–treasurer. Additional directors are MDs Schott, Jochimsen, R. A. Keller,* and J. D. Michael.* Doctor Schott succeeds Paul B. Mason, MD,* who had served as president of the clinic's executive committee continuously since 1955. Doctor Wood, as president of the Building Company, succeeds Doctor Schott, who held the post during the past two years. The Sheboygan Clinic was organized in May 1922 and is observing its 50th anniversary.

Milwaukee Psychiatric Hospital

. . . in Wauwatosa has announced plans for the establishment of a chemical dependency treatment center which initially will focus on alcoholism. Dean K. Roe, administrator, said that the hospital is developing the staff organization for the center and is planning to be open for treatment by May 1. He added that when the program is in full operation the center will accommodate 26 patients. The center was planned in cooperation with the Milwaukee Council on Alcoholism, Alcoholics Anonymous, De Paul Rehabilitation Hospital, St. Michael Hospital Mental Health Center, Medical Center of Southeastern Wisconsin, the Wisconsin Division of Mental Hygiene, and other agencies.

St. Luke's Hospital

. . . a 503-bed general hospital on Milwaukee's south side, has been accepted as an affiliate member of the Medical Center of Southeastern Wisconsin, according to an announcement by D. C. Jacobus, chairman of the Medical Center Council, and M. E. Knisely, president of St. Luke's. Programs involved in the affiliation include clinical clerkships for students of the Medical College of Wisconsin in psychiatry, physical diagnosis, preventive medicine and cardiovascular surgery; rotating internships in psychiatry; residencies, in cooperation with Veterans Hospital, in otolaryngology; and residencies, in cooperation with Milwaukee County General Hospital, in physical medicine, cardiovascular surgery, and general surgery for cardiovascular surgery.

Oshkosh Orthopedic Clinic

. . . gutted by fire last November 22, is tentatively scheduled to reopen July 1, according to MDs Lyall Stilp* and R. E. Buck,* co-owners. Two other orthopedists, MDs William Schneider* and William Jones,* also had their offices gutted by fire February 11 in Green Bay. A neurosurgeon, Robert Gruesen, MD,* also had his offices located in the Edlo Arcade building. The "burned out" doctors have continued their practices with the help of hospital facilities.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1972

1 Committee on Economic Medicine of SMS Council
1 SMS Division on Aging
2 Madison and Area Otolaryngologists Seminar
3 SMS Council Ad Hoc Committee on Annual Meeting
3 SMS Commission on Scientific Medicine
7 SMS Commission on Safe Transportation
7 Dane County Medical Society Board of Trustees
7 Madison General Hospital Surgical Staff
7 Madison Urological Society
7 Madison Anesthesiology Society
8 National Board Exams, Interns and Residents of University of Wisconsin Medical School
9 SMS Committee on Medicine and Religion
9 Madison Academy of Internal Medicine
10 Wisconsin Nutrition Council
15 Executive Committee and Board of Directors, Wisconsin Association of Professions
15 Dane County Medical Society Interhospital Medical Disaster Coordinating Committee
18 SMS Commission on Medical Care Plans
18 SMS Council Committee on Peer Review
19 SMS Commission on Medical Care Plans
21 University of Wisconsin Hospital Board
22 Board Exams for Professional Nurses
22 Ad Hoc Committee on Chiropractic
22 SMS Division on Aging
23 Board Exams for Professional Nurses
24 Wisconsin Clinic Managers
27 Dane County Medical Society Board of Trustees and Insurance Advisory Committee
28 Educational Program on Diabetes for Health Professionals
28 State Woman's Auxiliary Convention Committee
29 Dane County Medical Society Ad Hoc Committee on Health Maintenance Program
30 SMS Ad Hoc Committee on Section Delegate Representation

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

NEWS HIGHLIGHTS

• RACINE ACADEMY OF MEDICINE . . . newly formed with first meeting December 3, 1971, at St. Mary's Hospital in Racine. Guest speaker: H. David Friedberg, MD,* pediatric cardiologist and associate professor of medicine, Medical College of Wisconsin, Milwaukee. Organized for physicians interested in conducting monthly scientific discussions and studying developments in medicine, not to be confused with Racine County Medical Society. First elected officers: president, Victor A. Baylon, MD,* pathologist at St. Mary's Hospital; vice-president, Jerome Brooks, MD;* secretary, J. J. Veranth, MD;* and V. Michael Miller, MD,* treasurer.

• HOSPITAL-ORIENTED PRACTICES . . . of four physicians in Green Bay are now located in a leased part of the sisters' convent attached to St. Mary's Hospital Medical Center in Green Bay. Bruce Stoehr, MD,* a surgeon and one of the four, stresses that the new operation, which is named Hospital Division of West Side Clinic, has "an entirely separate operation from the hospital." Instead of adding an addition to the West Side Clinic, the leasing proposition was undertaken. The doctors are still in private practice and are still associated with the West Side Clinic. Those in the Division Hospital offices are MDs Robert Brault, chest surgeon; H. Axenrod,* urologist; B. Richardson, internist specializing in endocrinology; and Dr. Stoehr. Dr. Stoehr indicates that the new hospital division operation is helpful to the 24-hour emergency room coverage by providing more backup power nearby to the five doctors in family practice at the Clinic who are providing the ER service.

• ELLISON'S ATLAS OF SURGERY OF THE STOMACH AND DUODENUM . . . was published in November 1971 by C. V. Mosby Co., St. Louis. It is a textbook describing the surgical techniques of the late Edwin H. Ellison, MD who from 1958 to 1969 was professor and chairman of the Division of Surgery at the Marquette School of Medicine, now the Medical College of Wisconsin. The atlas has 70 plates with a total of 350 illustrations. Dr. Ellison and Robert H. Albertin, chairman of the Medical College of Wisconsin's Department of Audio-graphic Communications at Milwaukee County General Hospital, completed most of the illustrative work prior to Dr. Ellison's death in 1970. The text of the volume was contributed by men whom Dr. Ellison trained, with the exception of Richard H. Lillie, MD,* a Milwaukee surgeon and colleague. Larry C. Carey, MD, associate professor of surgery at the University of Pittsburgh School of Medicine and a former member of the medical college faculty, is editor of the atlas. Other contributors are Joseph C. Darin, MD,* William J. Schulte, MD;* Stuart D. Wilson, MD,* all of the MCW Division of Surgery; and William E. Evans, MD, a former medical college faculty member who is now with the Department of Surgery at Ohio State University College of Medicine. □

County Medical Society *happenings*

WINNEBAGO—*March 2, 1972:* Sixty-two members heard Hugh Davis, MD* lecture on "Indications and Effectiveness of Chemotherapy in Gastrointestinal and Breast Cancers and Lymphomas." Doctor Davis is from the Division of Clinical Oncology, University Hospitals, Madison.

SHEBOYGAN—*March 2, 1972:* Members of the Society and their spouses were guests of the Kohler Company for a plant tour and banquet. Attorney H. Doyl Taylor of Chicago, director of the American Medical Association's department of investigation, spoke at the dinner-program. According to a Kohler Company spokesman, the principal purpose of the tour and discussion meetings was to expand lines of communication with the physicians who administer to the needs of Kohler Company employes and their families. Following the tour, company officials and physicians discussed regulations that apply under the federal government's Occupational Safety and Health Act of 1970, and rules of Wisconsin's Department of Industry, Labor and Human Relations (ILHR). Hosts for the tour and meetings were Donald M. Rowe, MD,* director of the company's medical department, and William A. Forkner, MD,* staff member. Guests who took part in the dinner program included Earl Thayer of Madison, secretary of the State Medical Society of Wisconsin, and Ralph E. Gintz, Madison, administrator of the Department of ILHR's division of workmen's compensation. □

O. Tod Mallery, MD*

. . . medical director of Employers Insurance of Wausau, has been elected vice-president of the company. □

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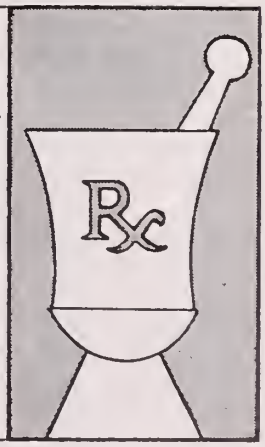

SECTION OPHTHALMOLOGY

APRIL 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING PROGRAM MAY 11

The Section on Ophthalmology will have a business luncheon Thursday noon, May 11, in conjunction with the State Medical Society's Annual Meeting, May 9–11, in Milwaukee.

The luncheon will be held in the Pere–Marquette Room (fifth floor) of the Sheraton–Schroeder Hotel. Tickets are $5.00; they may be ordered from the Section on Ophthalmology, SMS of Wisconsin, Box 1109, Madison, Wis. 53701.

Richard O. Schultz, MD of Milwaukee, professor and chairman of the Department of Ophthalmology, Medical College of Wisconsin, is chairman of the afternoon scientific program, which starts at 1:30 p.m. Thursday, May 11, in the Loraine Room of the Sheraton–Schroeder Hotel.

Leading off will be Herbert E. Kaufman, MD of Gainesville, Fla., professor of Ophthalmology and Pharmacology and chairman of the Department of Ophthalmology, College of Medicine, University of Florida. His topic is "Current Concepts in the Management of Herpetic Infections."

The lecture will be followed by a panel discussion by Milwaukee MDs Robert A. Hyndiuk, Arthur C. Kissling, Richard E. Lernor, and Richard O. Schultz.

At 3:30 p.m. Harry A. Easom, MD, associate clinical professor of Ophthalmology, Medical College of Wisconsin, and Guillermo de Venecia, MD, Madison, associate professor of Ophthalmology, University of Wisconsin Medical School, will discuss "Clinico–Histopathologic Correlation."

The Milwaukee Ophthalmological Society will host all ophthalmologists and interested physicians at a dinner in the University Club, starting at 6:00 p.m., Thursday, May 11. Doctor Kaufman will address the group on the subject, "The Medical and Surgical Treatment of Corneal Disease." Chairman of the dinner program is Howard W. Fiedler, MD of Milwaukee.

VISITING PROFESSOR LECTURER AT UW

James E. Miller, MD of Washington University, St. Louis, Mo., was visiting guest lecturer at the University of Wisconsin March 3–4. Doctor Miller gave several lectures on strabismus.

ORTHOPTIST AT UW

Miss Dale H. Blanche has joined the Department of Ophthalmology at the University of Wisconsin. She was born in Toronto, Canada, and graduated from Dalhousie University in Halifax, Nova Scotia, with a BA degree in 1966. She obtained her orthoptic training at the New York Eye and Ear Infirmary, New York City. She has both American and Canadian Orthoptic Council certification. Until February 1972, Miss Blanche was an orthoptist at the New York Eye and Ear Infirmary where her duties included not only orthoptic treatment but also the teaching of residents and orthoptic students.

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We ophthalmologists are sometimes asked by people what they can do with old eye glasses. New Eyes for the Needy, Inc., Short Hills, N.J. 07078, solicits metal frames in any condition, unbroken plastic frames with lenses, artificial eyes, soft cases, and precious metal scraps from old jewelry or watches. They cannot use loose lenses, contact lenses, or hard cases.

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It is run by volunteers and boasts it is an organization that does not ask for money.

RESEARCH TO PREVENT BLINDNESS GRANT

The University of Wisconsin Department of Ophthalmology has been awarded a grant of $2,500 from Research to Prevent Blindness of New York City to support and accelerate intensive studies of the eye and its diseases.

The award is unrestricted and is renewable each year. It provides the department with an unusual source of fluid funds, enabling it to respond immediately to scientific needs and opportunities as they occur.

DATES TO REMEMBER

May 11: Ophthalmology program and business meetings during the Annual Meeting of the State Medical Society. See details in this issue on page 43.

Sept. 25–29: Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Dallas, Tex.

Nov. 13–16: Meeting of the Section on Ophthalmology of the Southern Medical Association, New Orleans, La. □

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Arcilla, Senen S., 409 South 2nd St., Watertown 53094
Beardsley, Oliver B., Schiek Plaza, Rhinelander 54501
Cabatbat, I. B., Brandon Medical Center, Brandon 53919
Casey, Peter N., 2200 W. Kilbourn Ave., Milwaukee 53233
Cesarz, Thomas J., 8700 West Wisconsin Ave., Milwaukee 53226
Christmann, Robert P., 1313 Fish Hatchery Rd., Madison 53715
Cohen, Elsa B., 8700 West Wisconsin Ave., Milwaukee 53226
Cordero, Armenio C., 320 West Wilson St., Appleton 54911
Freeby, C. William, 222 W. College Ave., Appleton 54911
Ghahraman, Ali R., 5757 W. Oklahoma Ave., Milwaukee 53219
Grill, Karl P., 212 South 11th St., La Crosse 54601
Hull, David S., 1110 Links Ct., Brookfield 53005
Hyndiuk, Robert A., 8700 W. Wisconsin Ave., Milwaukee 53226
Kang, Seuk B., 1836 South Ave., La Crosse 54601
Lester, Gordon J., 1912 Atwood Ave., Madison 53704
Lie, Tjine H., 620 North 19th St., Milwaukee 53233
Luy, Enrique W., 118 Plain St., Sharon 53585
Muth, Donald M., 279 South 17th Ave., West Bend 53095
Nichols, Frank E., 1520 Vernon St., Stoughton 53589
Phillips, John R., 5625 Washington Ave., Racine 53406
Queniahan, Leandro M., 543 South Putnam, Whitewater 53190
Reynaldo, Primitivo I., 12307 West Dearbourn Ave., Wauwatosa 53226
Sharma, Mohini, 2320 North Lake Dr., Milwaukee 53211
Singh, Kanwar A., 312 Seventh St., Racine 53403
Sison, Aurora A., 1623 Fond du Lac Ave., Kewaskum 53040
Sison, Cesar V., 1623 Fond du Lac Ave., Kewaskum 53040
Tan, Simon, 1358 Wayne Rd., West Bend 53095
Virata, Rodelino L., 1836 South Ave., La Crosse 54601
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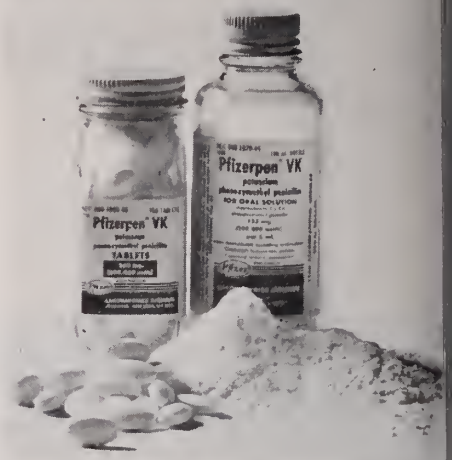
PFIZERPEN DOSAGE FORMS



Orange-flavored Pfizerpen VK for Oral Solution (potassium phenoxymethyl penicillin)
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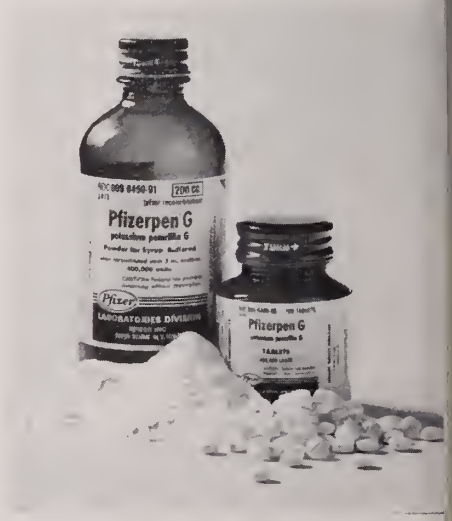

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400,000 units/5 cc.:
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800,000 units: bottles of 100.

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DEATHS

Pope, Frank W., Racine County, Feb. 2, 1972 □

Pre-Sate®
(chlorphentermine HCl)

CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children: Not recommended for use in children under 12 years of age.
Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
How Supplied: Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.
Full information available on request.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

May 4–5: Mental Health and the Aged: Perspectives and Concerns, conference workshops presented by Marquette University, Division of Continuing Education, at Plankinton House Hotel, Milwaukee.

May 8–10: Annual Meeting (House of Delegates), State Medical Society of Wisconsin, Milwaukee.

May 9–10: Wisconsin Clinic Managers Association, Downtowner Motor Inn, Milwaukee.

May 9–11: Annual Meeting (Scientific Program), State Medical Society of Wisconsin, Milwaukee.

May 11–13: Applied Genetics for the Clinician Conference, Wisconsin Center, Madison. Info: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

1972 NEIGHBORING STATES

Apr. 27–28: Region III Seminar of American Foundation for the Blind, Pheasant Run Inn, St. Charles, Ill. Seeks to carry forward services in such areas as medical and health, social welfare, rehabilitation, home assistance, recreation and transportation . . . to improve the economic and social status of the nation's aging blind population.

May 10–13: Postgraduate course on Fractures and Other Trauma, by Chicago Committee on Trauma of American College of Surgeons, Sheraton–Chicago Hotel, Chicago, Ill.

July 21–22: Annual Session, North Central Region, American Association of Medical Clinics, Holiday Inn, Urbana, Ill. INFO: John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

1972 AMA

June 18–22: Woman's Auxiliary 50th Anniversary, Convention, St. Francis Hotel, San Francisco, Calif.

June 18–22: AMA Annual Meeting, St. Francis Hotel, San Francisco, Calif.

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1973 WISCONSIN

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

* * *

Hospital Medical Staff Conference. May 15–19, Sun Valley, Idaho. Presented by Northwest Hospitals Education and Research Alliance, representing Idaho, Oregon, and Washington state hospital associations. Endorsed by the Idaho, Oregon, and Washington state medical associations. C. Wesley Eisele, MD, Conference Director. Presented specifically for benefit of physicians who are or will be in leadership roles in community hospitals. Two Wisconsin people are on program: Ray Scroggins, executive vice president of City National Bank and a trustee of Deaconess Hospital, Milwaukee; and Andre L. Delbecq, PhD, professor of management, Graduate School of Business, Industrial Relations Research Institute, University of Wisconsin, Madison. Mr. Scroggins' subject is "The Evolving Role of the Hospital Trustee," and Prof. Delbecq's is "How Do You Get Committees to Work." Tuition and registration fee: $125. Info: Northwest Hospitals Education and Research Alliance, c/o Washington State Hospital Association, 601 Broadway, Seattle, Wash. 98122.

Recent Progress in Hematology. Presented by University of Wisconsin, June 8–10. Topics of current importance in hematological diagnosis and management. Specifically disorders of coagulation, hemoglobinopathies, management of malignancies of the hemopoetic system, and status of blood transfusion. Conference structured to allow maximal participation by registrants in small groups with nationally known experts in the field. Guest faculty: Ernest Beutler, MD, City of Hope Medical Center; Frank H. Gardner, MD, Presbyterian–University of Pennsylvania Medical Center; Donald Pinkel, MD, St. Jude's Children's Research Hospital; Helen M. Ranney, MD, State University of New York at Buffalo; and Oscar D. Ratnoff, MD, Case Western Reserve University. Info: Miss Patricia Morton, Program Coordinator, Department of Postgraduate Medicine, 610 North Walnut Street, Madison, WI 53706.

Genetics for the Clinician. May 11–13, Wisconsin Center, Madison. Presented by University of Wisconsin Center for Health Sciences, Departments of Medical Genetics and Medicine, and University of Wisconsin Department of Genetics in cooperation with UW–Extension, Health Sciences Unit, Department of Postgraduate Medical Education. Conference objective is to present in concentrated fashion the current status of Genetics in Medical Practice and

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DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin
Madison
1972

ON-CAMPUS CONFERENCES

May 11–13: *Genetics for the Clinician*

June 2–3: *The North Central Dialysis and Transplant Conference*

June 8–10: *Recent Progress in Hematology*

July 22–23: *Ski Patrol Conference*

Aug. 28–Sept. 1: *Emergency Care Conference*

Oct. 20–21: *Podiatry Seminar*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

discuss future possibilities, both immediate and remote, which are appearing. To meet these ends, conference will include discussion and demonstration of: basic genetic principles for the clinician, foundations of genetic counseling, newer methodologies and applications of cytogenetics, prenatal genetics and *in vitro* assays of mutations in human cells, transplantation genetics, and current and future possibilities of genetic intervention. Conference structured to allow free exchange of views between registrants and faculty. Particularly of value to family physicians, internists, pediatricians, obstetricians, and those health professionals whose interests are in the fields of hereditary and familial disease, congenital abnormalities, mental retardation, and inborn errors of metabolism. AAFP has approved one credit for each hour of instruction. Registration fee: $100. Info: Coordinator of Postgraduate Medical Education, 702 Langdon St., Madison, WI 53706.

Symposium on Community Emergency Medical Services. Two-day comprehensive program at the Astroworld Hotel, Houston, Texas, May 26–27. Cosponsored by American Medical Association and Harris County Medical Society. Will focus on how a community can develop a comprehensive emergency medical program, review the roles of local, state, and national organizations, and assess the resources available to accomplish the goals. Conducted in cooperation with Texas Trauma Committee of American College of Surgeons, American College of Emergency Physicians, Emergency Department Nurses Association, City of Houston Department of Public Health, and Greater Houston Hospital Council. Program directed at practicing physicians, mayors and community leaders, fire department chiefs, hospital emergency room staffs, emergency room nurses, and state and local health departments. Registration fee: $50. Info: Harris County Medical Society, 400 Jesse H. Jones Library Building, Texas Medical Center, Houston, Texas 77025.

Mental Health and the Aged: Perspectives and Concerns. Thursday & Friday, May 4–5, Plankinton House Hotel, Milwaukee. Conference workshops presented by Marquette University, Division of Continuing Education, in cooperation with The Milwaukee Mental Health Association; Milwaukee District of the Division of Mental Hygiene, State Dept. of Health & Social Services; and Milwaukee Region of the Division of Family Services, State Dept. of Health & Social Services. Registration, including two luncheons and evening banquet: $45 (persons requiring one night's lodging), $35 (no lodging), $20 (students—limited). Arrangements pending for in-service training credit for social workers, nursing home administrators, and nurses. Physicians on program: Ruth Jansen, MD, psychiatrist and chief of staff, Mental Health Center, South Division, Milwaukee County Institutions—*Mental Health, Physical Health and Treatment Modalities;* Constantine Panagis, MD, director, long-term care, Milwaukee County Institutions—*Health Care Instead of Medical Cure;* Raymond Headlee, MD, professor of psychology, Marquette University and president-elect, Wisconsin Psychiatric Association—*Mental Health: A Changing Scene.* Doctor Headlee is the banquet speaker, Thursday evening. Lt. Governor Martin J. Schreiber will be the Thursday luncheon speaker, discussing "Wisconsin's Elderly: Our Concern." Workshop sessions include the following distinguished guest speakers: Mrs. Marie McQuire, program advisor for problems of the elderly, Social Services Division, Department of HUD, Washington, DC; Martin Meyer, PhD, director of Division of Planning & Evaluation, Indiana Department of Mental Health; Leonard Gottesmann, PhD, Philadelphia Geriatric Center; Alphonso Anderson, National Council on the Aging, Washington, DC; and State Senator Dale T. McKenna.

Psychopharmacology and the Aging Patient. May 29–31, Center for the Study of Aging and Human Development, Duke University, Durham, N. C. Conference to discuss clinical use of psychoactive agents and recognition and management of psychiatric syndrome of the elderly. Info: Mrs. Dorothy Heyman, Box 3003, Duke University Medical Center, Durham, NC 27710.

Cancer of the Digestive Tract. Postgraduate course sponsored by American Gastroenterological Association, July 20–22 at Aspen Institute for Humanistic Studies, Aspen, Colo. Designed for practicing physicians. Approval has been requested for 12 hours credit by American Academy of Family Physicians. Registration fee: $80 for AGA members; $100 for non-members; $25 for those in training status. Info: Mrs. Frances T. Chalmers, AGA Postgraduate Course, Box 190, McLean, Va. 22101 (tel. 703/356–2693).

National Conference on Cancer Chemotherapy, sponsored by American Cancer Society, National Cancer Institute, at The Biltmore Hotel, New York City, June 1–3, 1972. All members of the medical and related professions, research investigators, and medical students are invited to attend. No registration fee. Preregistration requested. INFO: Sidney L. Arje, MD, Coordinator, National Conference on Cancer Chemotherapy, % American Cancer Society, 219 East 42nd Street, New York, NY 10017.

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February 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for February 1972:

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Dr. Grinde—Bell Account

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Indianhead Chapter of Wisconsin Academy of Family Physicians, Wyeth Laboratories ---------- Contributions

MEETINGS *continued*

National Conference on Human Values & Cancer, sponsored by the American Cancer Society, at Regency Hyatt House, Atlanta, Ga., June 22–24, 1972. This Conference will be concerned with understanding the problems of the cancer patient from inception of disease to cure or failure. Also, the effects on the family and professionals who are directly concerned. Emphasis will be placed on the humanistic problems of the patient including interpersonal relationships, rehabilitation, employability, insurability, the right to know, the spiritual needs, and the hopes for miracles. Members of the medical and related professions, and other individuals concerned with the cancer patient are invited to attend. No registration fee. Preregistration is requested. INFO: William M. Markel, MD, National Conference on Human Values & Cancer, American Cancer Society, Inc., 219 East 42nd Street, New York, NY 10017.

American Association of Medical Clinics, North Central Region, will hold its annual session July 21 and 22 at the Holiday Inn, Urbana, Ill. The meeting will be hosted by the Carle Clinic Association, Urbana, and will commence with an afternoon registration period, Friday, July 21.

The two-day session will include panel discussions on: (1) computers in medicine, (2) physicians' assistants, and (3) clinics and medical education.

All interested physicians, clinic administrators, and observers are invited to attend. Additional information may be obtained by contacting John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

American Association for Automotive Medicine, Sixteenth Annual Conference at the Carolina Inn, Chapel Hill, NC, October 18–21, 1972. Proposal of a paper for presentation is due April 15 to: John D. States, MD, Chairman AAAM Program Committee, 15 Prince St., Rochester, NY 14607. Areas of special interest with regard to medical aspects of traffic safety which may suggest a subject: (1) driver standards—licensing, (2) alcohol and drugs, (3) visual, (4) emergency medical services, (5) protective helmets and clothing, (6) restraint systems, active and passive, (7) motorcycles, (8) vehicle design, (9) medicolegal, and (10) data collection and analysis. INFO: James L. Weygandt, MD, President-elect, AAAM, 716 Monroe Street, Sheboygan Falls, Wis. 53085.

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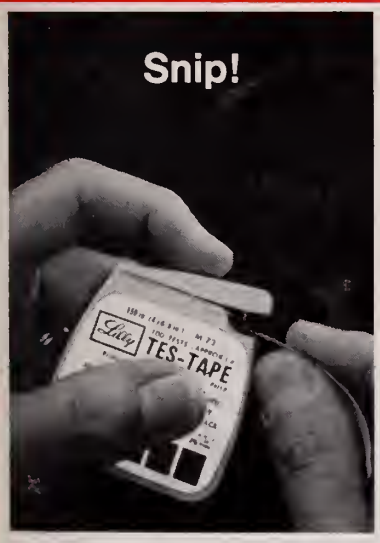

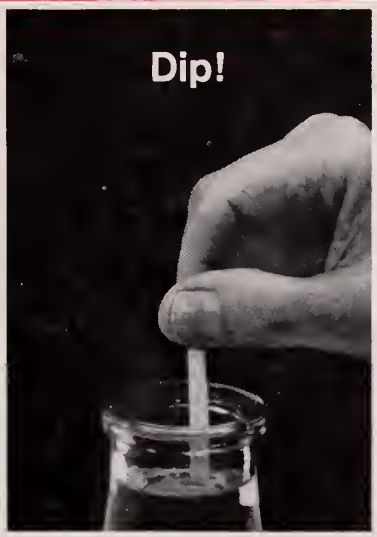

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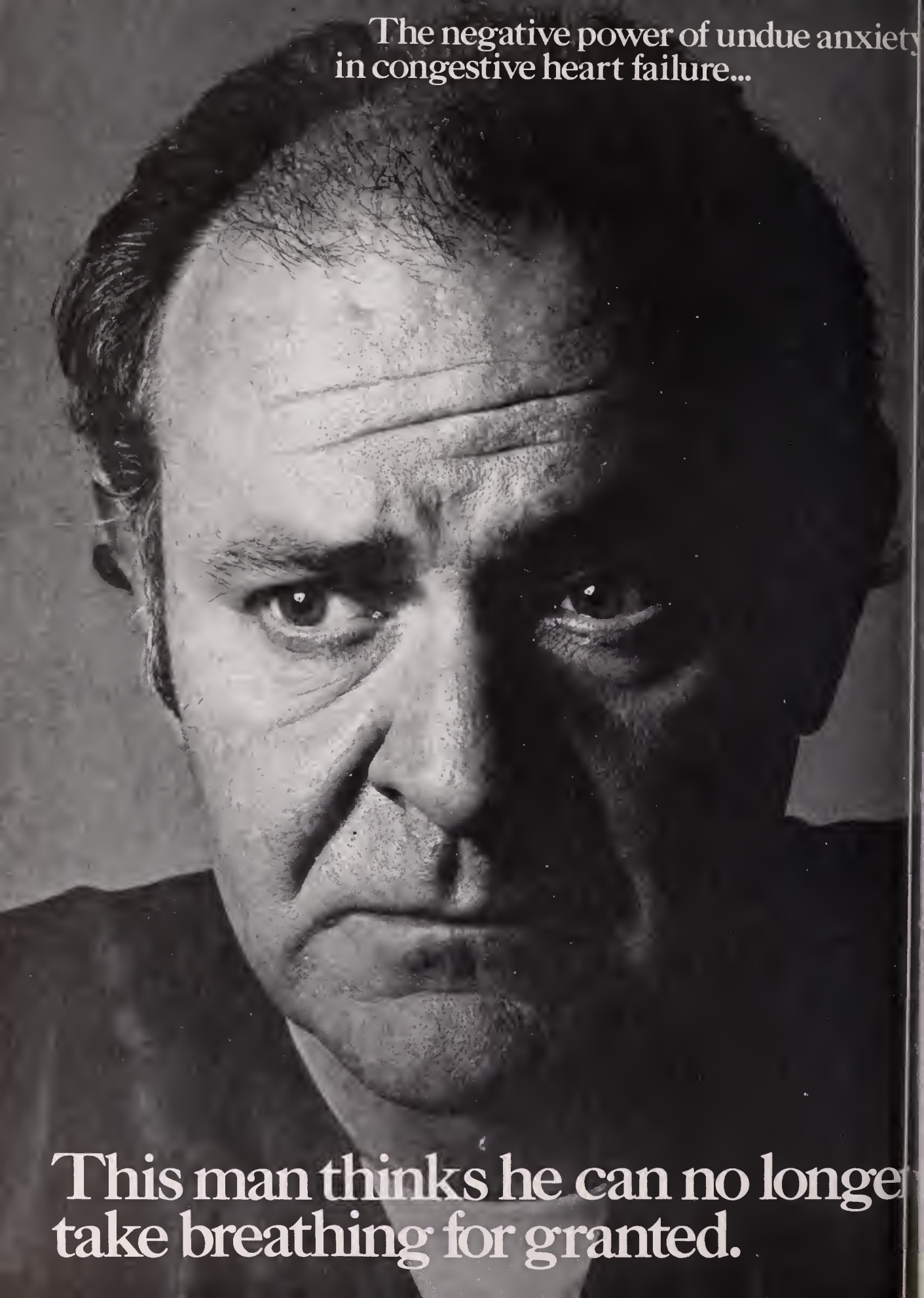
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in congestive heart failure...
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take breathing for granted.

the wisconsin medical journal

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

THE NEW PRESIDENT

ROBERT F. PURTELL, MD

■ Dr. Robert F. Purtell, general practitioner in the Milwaukee area since 1932, assumed the office of President of the State Medical Society of Wisconsin during the Annual Meeting held this month. Born on Aug. 4, 1908, in Monches, Wisconsin, Doctor Purtell graduated from the Marquette University School of Medicine and served his internship and residency at Milwaukee County General Hospital from 1929–1932. He was licensed in Wisconsin in 1931. ■ In 1933, Doctor Purtell joined the faculty of Marquette University and served in a teaching capacity for over 30 years. From 1946–1952, he was a member of the State Medical Society's Committee on Maternal and Child Welfare and in 1953 became its chairman, serving until 1956. A member of the Wisconsin Academy of Family Physicians, he was elected its president in 1956. In 1959, Doctor Purtell was named chairman of the Postgraduate Education Committee at Marquette University School of Medicine. ■ From 1940–1960, he was a member of the Blue Cross Board of Directors and served as a first vice-president. In 1964, Doctor Purtell was elected president-elect of The Medical Society of Milwaukee County and served as its president in 1965. He also is a member of the Milwaukee Academy of Medicine, American Academy of Family Physicians, and American Medical Association. ■ In 1971, Doctor Purtell was elected president-elect of the State Medical Society of Wisconsin and in this capacity served as a member of the Executive Committee of the Council, the Commission on Public Policy, and the Commission on Medical Care Plans. ■ Doctor and Mrs. Purtell, the former Florence McCormack, have five children: Dr. Robert F., Jr., who is in general practice with his father in Milwaukee; Mary (Mrs. John King), a graduate medical technician from Marquette University; Dennis F., an attorney from Milwaukee; Michael F. and Ann, also in Milwaukee. □

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Now You See Us, Now You Don't

In almost every newspaper, and in every community a strange phenomenon seems to be upon us. The role of the physician has become diluted far beyond the medical prerogative we learned in medical school. Not only the ancillary disciplines are demanding and getting a larger share of the medical responsibility, but groups far removed from our ideas of medical practice are becoming an all too real part of the health picture. Will we, like Alice in the little picture, be drawn into some secondary position behind the looking glass of the world today? The answer depends partly upon these other groups, forming rapidly to "aid in medical delivery systems." It also depends upon the body politic and what choices are made to facilitate health services, be this medical, social or chiropractic. It depends mightily upon how convincingly we as doctors approach the task of public education in matters of health, and of organization of ourselves and of others. We can seize the initiative, as indeed we are trying, or we can merely react negatively when others prompt us.

The first impulse when offended by dissonant groups might be to unloose a diatribe against the group. Yet in a basic sort of logic, we know an attack will only backfire, for after all who can be truly against those who would band together in the interest of better health services for all. The answer would be quick and obvious: the countercharge that physicians oppose such a group because physicians are greedy and don't want anyone else to get into the health service field. Now our assertion that we have moved toward fuller use of physicians' assistants and that we have for decades involved ourselves in the community will count for naught, if we cannot convince the public by our rhetoric as well as by our actions.

The phenomenon of group formation seems to be a desperate crystallization of the need for organization itself. Whether physicians are seen as failing to supply adequate medical coverage, or whether

physicians are excluded because some feel we could not work with any finesse in an action group, is not known.

It is this strange change, in the medical arena, to which your attention is now directed. In a time of change, very little holds firm. But we ask ourselves how can that be true of medical knowledge, for after all, the facts are clear to all who care to look. By careful scientific study we have reached our present state of efficiency, and even of general public credibility (see last month's editorial). Yet, the crucial phrase may be "for all who *care* to look." If strong social needs are more urgent, then scientific discipline fades into the background. Or, if people sincerely believe that they have the "scientific" answers, then there is no need to study, or to consult those who have.

In Brazil, according to a recent visiting lecturer to my class of freshmen medical students, all professional fields except engineering, have been effectively taken over by the radicals, who insist they know what is best. This professor, both MD and PhD, teaches scientific research method in the medical school. He reports that in another department, a colleague of his had been teaching research methodology in graduate psychology. At final examination time the student representatives presented the professor with twenty pages of mimeographed material and demanded, in the name of student rights and social relevance, that they be examined on this material, not on what the professor had been teaching. Their twenty pages were divided into four parts. The first three were direct quotations from Mao, from Che, and from other similar writers, on how knowledge is won, that is, the writer idea of relevant quotations about "scientific method;" the last section was a detailed study of Brazilian business, done by an American, showing that American bankers and investors were responsible for downgrading of Brazilian business. The professor refused to substitute this for course material, in final examination. Upon his appeal to his dean, the professor was fired from the university and the students were supported in their demand, apparently out of fear on the part of the administration of being accused of not taking the needs of the students into account. Granted this is an extreme story, and in a far distant land, and may have other facets to it. Yet we live in an age of extremes. But the point is *not* political at all. The point is that ideas and needs can become so insistent that all pretense at scientific discipline breaks down. This is the real danger we face. Unless we know something of the forces we are facing we stand the danger of being stampeded into lofty withdrawal from such social happenings, or worse to explode with exasperation at our unused but hard won talents. Both courses can only further isolate us from the mainstream of medical affairs and perhaps justify and even stimulate the formation of such desperate groups, leaving medicine outside or in a relatively minor capacity.

Only a seer would pretend to know whether this will continue, but we all suspect that it will. Only a guru could tell us how to meet the challenge when and if it comes, but we all have to summon a bit of the guru at times like this. A little knowledge can be a helpful thing, particularly if thought out now.—RH

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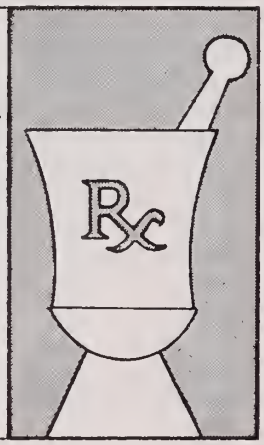
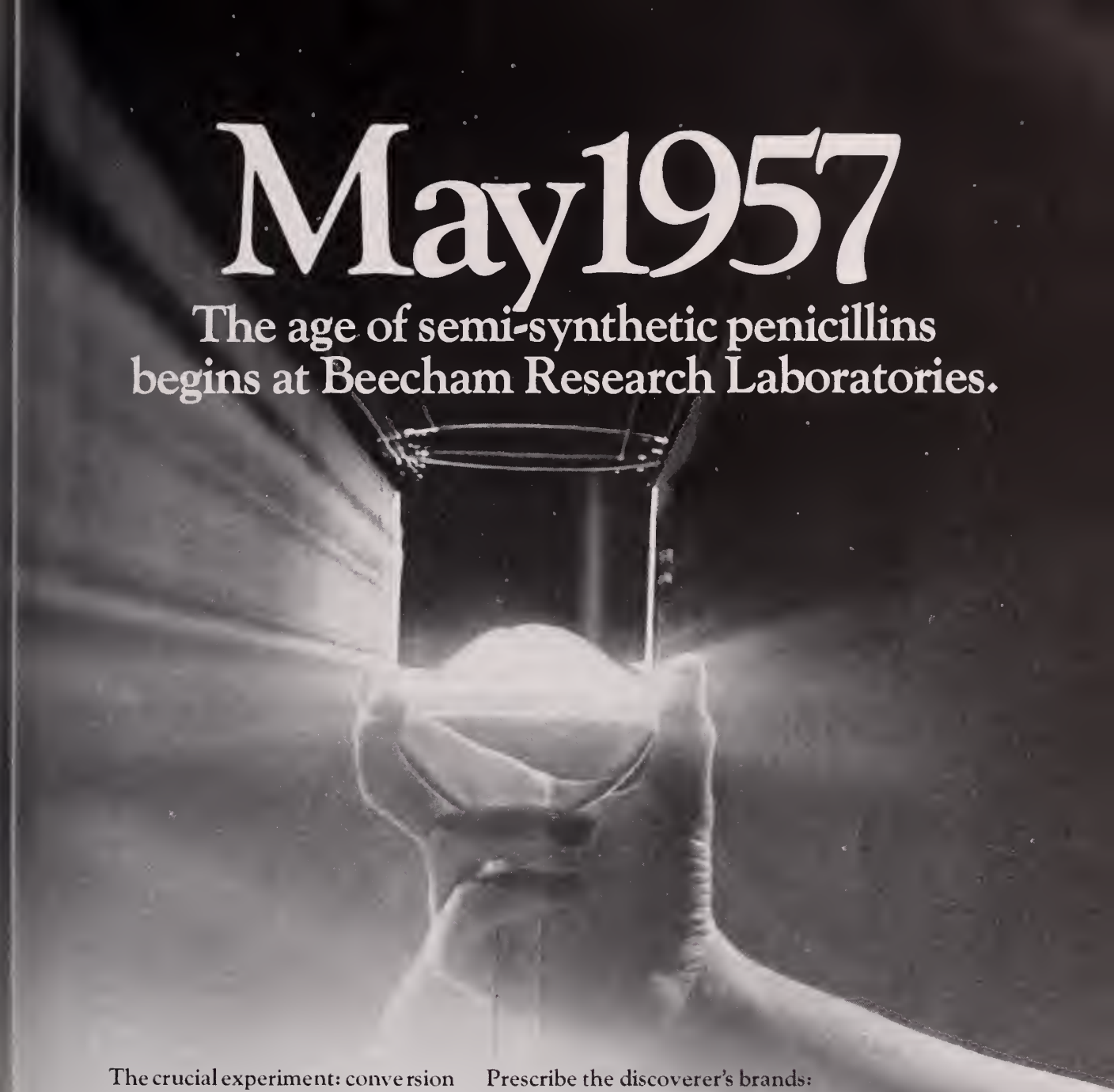


Addendum

Dr. R. W. Hammel, professor of pharmacy administration at the University of Wisconsin—Madison, has responded to the editorial "Pejorative Prescriptions," (March 1972) in a most helpful way. While in no manner detracting from the main thrust of my presentation, he asked that several points be clarified. One is that there is no careful study which shows that *many* prescriptions written are never filled. He quotes his own research, published in Vol. NS4, No. 7, July 1964, of the Journal of the American Pharmaceutical Association, in which he found, in a midwest community, that only three percent of prescriptions written and painstakingly traced, were not filled, after ten days. Apparently certain legislative committees have used the loose statement about unfilled prescriptions (often heard, not just in my editorial), to move toward generic prescribing, assuming the failure to fill a prescription was due to inability to afford the prescribed drugs. Of course, under Title XIX this is no longer an issue, nor was cost of drugs even considered in the editorial. The second point, that prescriptions were not filled because the druggist did not have the required medicine or dosage available, was not pertinent to my editorial, either. Doctor Hammel's researches, published jointly with Dr. Paul Williams, clearly show this is not a factor. It is a pleasure to report these additional facts. My reference was to the work of medical sociologist, R. H. Blum, whom I believe did his researches in California.—RH □

May 1957

The age of semi-synthetic penicillins begins at Beecham Research Laboratories.



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SPECIAL TO THE JOURNAL

Fluoridation in Cudahy

Five-Year Evaluation

JOSEPH M. DOHERTY, DDS, MPH
Madison, Wisconsin

BETTY KRIPPENE, RDH, MPH
Fond du Lac, Wisconsin

The city of Cudahy, with a 1970 population of approximately 22,000, began fluoridating its public water supply on Nov. 7, 1966. Hydrofluosilicic acid was added to the water supply to adjust the fluoride ion content from 0.1 to 1.0–1.5 parts per million of water.

In October 1966 a dental survey was made to establish a baseline of caries experience among school children. Significant deviations from the baseline, as determined by future surveys, would provide a measure of the effect of the fluoride additive.

A second survey five years later in October 1971 assessed the benefits that could be expected during that time period.

Both surveys were conducted by staff members of the Dental Health Section of the Wisconsin Division of Health at the request of the Cudahy Health Department, with the approval of the local dental society and in cooperation with the public and private school administrators.

Examination Procedure

Every attempt was made to conduct the examinations under similar conditions. The same staff members were used for both surveys. Examinations were made using mirrors and explorers with illumination provided by portable dental lights. Volunteers served as recorders and monitors. Dental caries experience was noted and recorded using standardized technics, def/DMF indices (Table 2), for measurements.

The children, examined with parental consent, were divided into residents and non-residents on the basis of a Resident History Form completed by the parents. A child was considered to be a continuous resident if he had not been absent from the area served by the Cudahy municipal water supply for a period of more than 90 days in any one calendar year. Deciduous teeth (def) of the kindergarten children and the permanent teeth (DMF) of the fourth and eighth grade children were used for comparative purposes.

Only those children who had been continuous residents of Cudahy for the preceding five years could logically be used for comparison with the baseline as is done in Tables 2 and 3. However, in Table 4 both residents and non-residents are used for comparisons as to the overall dental conditions of the children examined.

Optimal results from fluorides in water are dependent upon the maintenance of a fairly constant level of fluoride ion at 1.0–1.5 parts per million in the Wisconsin temperature zone. The fluoride residuals of the city of Cudahy for the five-year period are shown in Table 1. The desirable fluoride levels for Cudahy have been well maintained as determined by monthly water samples submitted to and examined by the Wisconsin Laboratory of Hygiene.

TABLE 1—*Average Monthly Fluoride Residuals in Parts Per Million (PPM)*

City of Cudahy
November 1966–October 1971

	1966	1967	1968	1969	1970	1971
January		1.3	1.1	1.3	0.8	1.1
February		1.4	1.7	1.1	1.1	1.2
March		1.3	1.9	1.1	1.1	1.1
April		1.3	1.1	1.0	1.3	1.0
May		1.0	0.8	1.0	1.0	1.9
June		1.0	1.1	1.0	0.9	NR
July		1.1	NR	1.0	1.2	1.2
August		NR	1.2	0.9	1.1	1.2
September		1.0	1.2	1.2	1.1	1.1
October		1.2	1.1	1.2	NR	1.2
November	1.3*	1.3	1.3	1.1	1.1	
December	1.3	1.1	1.1	1.1	1.1	

*Treatment started Nov. 7, 1966.
NR No report.

Survey Findings and Discussion

A comparison of the levels of decayed, extracted/missing and filled teeth (def/DMF) of resident children surveyed in Cudahy in 1966 and of residents surveyed in 1971 is shown in Table 2. The data indicate reductions in caries experience in each grade group—55.7 percent for the kindergarten children; 31 percent for the fourth graders; and 7.4 percent for the eighth graders.

The full impact of the benefits of fluoridation in a five-year post fluoridation survey can be measured only for the kindergarten children. This is so because only those children have consumed fluoridated water since birth. The 55.7 percent reduction in dental caries experience in Cudahy is within expectations as demonstrated by other communities with fluoridated water in Wisconsin.

The reductions in dental decay shown by the fourth (31%) and eighth (7.4%) grade children, even though they had not consumed fluoride in the early period of permanent dentition formation, is supported by the work of Klein[1] and others. They found that partial protection is received by older children even though they were born and resided in the community prior to fluoridation. The earlier the age of introduction and the longer the exposure

Doctor Doherty is Deputy Chief, Section of Dental Health, Wisconsin Division of Health; and Ms. Krippene is Dental Health Consultant, Wisconsin Division of Health—District Three Office.

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TABLE 2—*def/DMF Teeth Rates Among School Children by Grade for Cudahy Residents Only*

Grade	1966						1971						% Decrease in def/DMF Teeth Rate 1966–1971
	No. of Child.	d/D	e/M	f/F	Total def/DMF	Rate def*/DMF†	No. of Child.	d/D	e/M	f/F	Total def/DMF	Rate def/DMF	
Kgn.	168	315	32	314	661	3.93	317	226	9	317	552	1.74	55.7
4th.	143	154	8	189	351	2.45	157	83	3	180	266	1.69	31.0
8th.	80	71	3	366	440	5.50	74	64	7	306	377	5.09	7.4

*def refers to caries attack count of deciduous teeth, i.e., the average number of decayed, extracted and filled deciduous teeth per kindergarten child. The def rate was determined for the kindergarten age group only and is obtained by dividing the sum total of d+e+f teeth by the total number of children examined.

†DMF refers to the caries attack count in permanent teeth; that is, the average number of decayed, missing and filled permanent teeth per child. The DMF rate was determined for the fourth and eighth grade children only and is obtained by dividing the sum total of D+M+F teeth by the total number of children examined.

time to fluoride, however, the greater the protection against dental decay experience.

A second criterion commonly used for measuring the effectiveness of fluorides is a comparison of the percentage of caries-free children.

An increase in the percentage of caries-free children is evident in the kindergarten and fourth grade groups in Table 3. The kindergarten children showed an increase in caries-free children from 29.8 to 52.9 percent; the fourth grade increased from 18.9 to 31.8 percent.

Table 4 shows that there has been an increase in the percentage of Filling Needs Met (FNM) for the kindergarten and fourth grade groups while the eighth grade has remained fairly constant. The kindergarten group increased from 42.7 to 54.6 percent and the fourth grade group increased from 56.6 to 62.2 percent, while the eighth grade group decreased from 79.8 to 78.4 percent.

The percentage of children who need dental care decreased in all three grade groups. The kindergarten group decreased from 42.2 to 26 percent, while the fourth and eighth grade groups decreased from 38.7 to 31.8 percent and 41.9 to 39.5 percent, respectively.

It is gratifying to note in Table 4 the increase in the percentage of Filling Needs Met as well as the increase in the percentage of children who have had all of their dental corrections completed. This increase from 1966 to 1971 would seem to indicate a greater awareness on the part of the community toward the need for receiving and maintaining good dental health.

TABLE 3—*Caries-Free* Children by Grade for Cudahy Residents Only*

Grade	Number Examined		Number Caries Free		Percent Caries Free	
	1966	1971	1966	1971	1966	1971
Kgn	168	317	50	168	29.8	52.9
4th	143	157	27	50	18.9	31.8
8th	80	74	3	3	3.8	4.0

*Caries Free indicates that there was no evidence of present or past dental decay at the time of the examination.

Summary

Community water fluoridation began in Cudahy on Nov. 7, 1966, and has been routinely maintained at the recommended level of 1.0–1.5 parts per million. In October 1966 a dental examination was made of the kindergarten, fourth and eighth grade children to provide baseline data for the future evaluation of the benefits of fluoridation. In 1971 the first follow-up dental survey was made. A comparison of the survey findings with the baseline data reveals that substantial reductions in the dental caries of kindergarten children have occurred since fluoridation was instituted. A greater percentage of the filling needs had been met in 1971 than in 1966 except for the eighth graders, and a greater percentage of the children examined in 1971 had all of the dental corrections completed.

REFERENCE

1. Klein H: Dental effects of accidental fluoridated water, I. Dental caries experience in deciduous and permanent teeth of school age children, *J Am Dent Assn* 36:443–453, 1948. □

TABLE 4—*Dental Status by Grade for Cudahy Residents and Non-Residents**

Grade	1966						1971					
	No. Exam.	%* FNM	Corrections Completed†		Need Dental Care‡		No. Exam.	% FNM	Corrections Completed		Need Dental Care	
			No.	%	No.	%			No.	%	No.	%
Kgn	339	42.7	53	24.2	166	42.2	358	54.6	72	20.1	93	26.0
4th	341	56.6	107	39.9	161	38.7	324	62.2	102	31.5	103	31.8
8th	201	79.8	100	52.6	90	41.9	152	78.4	72	47.4	60	39.5

*% of FNM refers to the percentage of filling needs met; that is, the percentage of carious teeth that have been restored to normal function. This figure is determined by dividing the number of filled teeth by the sum total of D+M+F as found in Table 2.

†Corrections Completed is based on all decayed teeth having been restored to normal function.

‡Need Dental Care is based on the presence of decayed teeth.

"A Well Deserved Tribute" to Warren Williamson, MD

WHILE DOCTORS GENERALLY have a deep interest and concern for the community they serve, few receive the recognition they deserve. But Dr. Warren Williamson of Racine was accorded that recognition recently upon completion of his term as president of the Racine Area Chamber of Commerce. The *Racine Journal-Times* March 23 issue carried this editorial comment:

"Dr. Warren Williamson—a practicing physician who has given generously of his time in civic affairs—recently received a standing ovation from his fellows at a meeting of the Racine County Medical Society.

"The tribute was prompted by Dr. Williamson's completion of a term as president of the Racine Area Chamber of Commerce.

"Dr. Williamson is the only member of the medical profession to serve as president of the Chamber during its 59-year history.

"He also goes down as one of the Chamber's most effective leaders. Dr. Williamson was a 'working' president who devoted a great deal of personal effort toward accomplishment of the Chamber's goals.

"Dr. Williamson played a key role in helping resolve the Mount Pleasant—City of Racine landfill controversy which resulted in the use of the Oakes landfill site and the creation of Huck industrial park.

"He also was involved in many areas of industrial and commercial development which contributed to the economic welfare of the Racine area during the past year.

"During his term, the Racine Business President's Council was established to bring about greater cooperative efforts toward solving area problems.

"He concerned himself with how the Chamber of Commerce can better serve its own members. An example of this was the inception of a medical and hospitalization program to meet the needs of smaller firms.

"There were numerous other activities in Dr. Williamson's busy and fruitful year as president of the Chamber, including fire and police protection, inter-government relationships, state and national legislation, conventions and visitors and consumer-business relations.

"All of these Chamber responsibilities were in addition to Dr. Williamson's duties as chairman of the board and medical director of the A-Center at Lincoln Lutheran Home, president of Family Planning, Inc., and director of the Health Division of the Southeastern Wisconsin Regional Planning Commission.

"It seems to come natural for Dr. Williamson to assume a leadership role in whatever organization or purpose he serves.

"It is highly unusual for a doctor to immerse himself so deeply in civic affairs.

"Every community has a few citizens who are willing to give of their time and talent and make personal sacrifices for the general good.

"Dr. Warren Williamson is one of this special breed of civic-minded leaders and he deserves recognition for his efforts."

And comments of the Chamber's executive vice president, Darrell Wright, are equally indicative of Doctor Williamson's civic impact:

"Warren, during his three-year term as a director, added immeasurably to the stature and effectiveness of the entire Chamber through his integrity, drive and forthrightness.

"He asserted these same qualities as he assumed the Presidency and he added a willingness to stand up and be counted. He also was a working president who devoted a great deal of personal effort toward the accomplishment of his goals.

"His personal commitment to the involvement of more professional people in the civic and economic welfare of the community was especially spectacular." □

American Association of Medical Assistants, Inc.

Wisconsin Society

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JUST AS YOU, the physician, must continually update your skills, so should your medical assistant. Her knowledge of new procedures and advances in medicine must keep pace with yours.

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The American Association of Medical Assistants, Inc.—Wisconsin Society is a non-profit organization. It is not nor shall it ever become a trade union or collective bargaining agency. Its objectives are:

(1) To inspire its members to give honest, loyal and efficient service to the profession and to the public which they serve.

(2) To strive at all times to cooperate with the medical profession in improving public relations.

(3) To provide educational services to increase the knowledge and professionalism of its members and to stimulate a feeling of fellowship and cooperation among its members.

Qualified physicians are elected as advisors to counsel with officers and committee chairmen throughout the year.

Members participate in organized educational activities—planned meetings, study groups, field trips, lectures, continuing education programs, workshops and group discussions. Seminars as well as the annual state and national conventions offer opportunity for professional and personal development.

One of the major accomplishments in the association's continuing program to raise the status of its membership is voluntary Certification. Those passing the written test become Certified Medical Assistants, either Administrative or Clinical.

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WISCONSIN MEDICAL JOURNAL
Vol. 71, No. 5 MAY 1972

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Report on 1972 House of Delegates Session; Dr. Purtell Installed; Dr. Derus President-elect

Robert F. Purtell, MD, Milwaukee, was installed as the 114th president of the State Medical Society of Wisconsin at the third session of the House of Delegates which met May 8–10 in Milwaukee during the Society's Annual Meeting.

Elected to the post of president-elect was Gerald J. Derus, MD, Madison. Dr. Derus will become president next March.

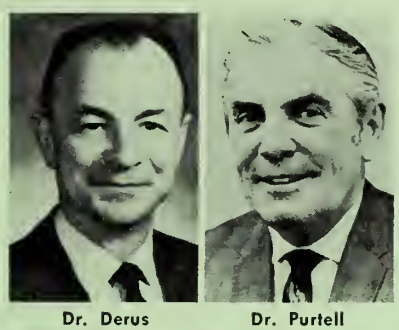
Dr. Purtell has been practicing family medicine in the Milwaukee area since 1932. He graduated from Marquette University School of Medicine in 1930, and served his internship and residency at Milwaukee County General Hospital, 1929–1932.

He served as president of the Medical Society of Milwaukee County in 1965 and was president of the Wisconsin Academy of Family Physicians in 1956.

He served for 10 years on the State Medical Society's Maternal and Child Welfare Committee, and was its chairman for three years.

He has served as a Milwaukee County delegate to the State Society since the 1940s.

Dr. Derus, also a family physician, has been practicing family medicine in Monona since 1953, after completing his training at the University of Wisconsin Medical School and St. Mary's Hospital, Madison. Since 1955 he has practiced at the Monona Grove Clinic. He was born July 21, 1926, in Kaukauna.



Dr. Derus Dr. Purtell

He is currently president of the Dane County Medical Society and has served as chairman of the State Society's Commission on Scientific Medicine for the past year. He has also served as president of the Dane County Chapter of the Wisconsin Academy of Family Physicians.

He has been actively involved in establishment of the University of Wisconsin's Family Practice Program, and he is currently an assistant clinical professor of family practice at the UW Medical School.

Hearing: AMA Needs Vigorous Change

Criticisms, recommendations and praise for the American Medical Association were all heard May 10 in Milwaukee at the nation's first open hearing on the AMA's future.

Four members of the AMA's 9-member Council on Long-Range Planning and Development and members of the Wisconsin AMA delegation heard 28 physicians testify at the all-day session in the Marc Plaza during the State Medical Society's Annual Meeting.

All of the physicians who testified seemed pleased that the AMA was holding the hearings and many said they thought poor communications between the association and the membership could be a reason for misunderstandings in the past.

Suggestions made for strengthening the AMA and making it more responsive to the needs of individual physicians included:

- Direct election of AMA delegates
- Concentrated efforts to actively involve interns and residents in medical society and AMA activities
- Changes that would enable physicians to become a part of the leadership structure at earlier ages

Physicians from small-town and rural communities urged the AMA to devise ways to end or alleviate the problem of physician maldistribution. Several witnesses called upon the AMA to represent their views more forcefully in Washington.

Some of the other points made by testifying physicians were that the AMA should:

continued on page 32

Presidential Citation to Honorable John Byrnes

The Honorable John W. Byrnes, long-time U.S. Congressman from Wisconsin's Eighth Congressional District, became the tenth person to receive the State Medical Society's Presidential Citation at the Public Affairs Breakfast May 9.

In making the presentation, immediate past president George A. Behnke, MD, cited Rep. Byrnes for "his outstanding leadership in behalf of the United States of America and our State, and for his contributions to the public health and welfare."

With his announcement last January that he would not seek reelection this fall, Rep. Byrnes is completing over 30 years of public service. He is now the senior Republican on the powerful House Ways and Means Committee.

In his speech to the 200 persons attending the breakfast, Rep. Byrnes said he was more concerned about "government tampering with the health care delivery system (than with) a government system for financing that care."

He predicted that some action would be taken within a year on a federally financed system of health insurance coverage for catastrophic illness for all Americans. He said he also expected this coverage to be accompanied by a system of government scrutiny over the delivery of health care.

He said, "I would hope that the public and the Congress could keep financing and delivery of health care separate as much as possible."

He said Congress probably will adopt "a plan for catastrophic health insurance protection separate and apart from national health insurance. This is a subject which has great appeal. It is an essential supplement to any public health insurance plan that may be adopted. But it probably will depend on the amount of insurance coverage an individual has."

THE HON. JOHN W. BYRNES (left) was presented the State Medical Society's Presidential Citation May 9 by outgoing president Dr. George A. Behnke.

He said he hoped such a plan "would be considered only as a supplement and be designed only after the basic (national) plan has been developed. I think (House Ways and Means) Chairman Mills shares this view."

He said he expected any such plan woud be finally ironed out in a Senate–House conference committee and he could not predict what its final dimensions would be.

Rep. Byrnes also said he was most concerned about the fate of the Bennett Amendment on peer review, introduced in connection with HR-1, the bill considering national health insurance.

He said, "Here, it seems to me, we come face to face with the interrelationship between financing on the one hand and the matter of the quality, the quantity and the cost of medical care on the other. I believe firmly that in resolving any problem related to the health delivery system, we must depend on the medical profession itself. But it is equally clear to me that the profession must face up to its responsibility in this area."

He noted the medical profession's efforts in this area, mentioning particularly Wisconsin Health Care Review, Inc., formed in December by the State Medical Society of Wisconsin, the Wisconsin Hospital Association, and the Wisconsin State Dental Society.

Council Honors PACE Leader

Harold J. Kief, MD, Fond du Lac, was presented with a special certificate of appreciation by the State Medical Society's Council May 9. The award recognized "his unstinting efforts to encourage the medical profession in the proper exercise of its civic responsibility for the improvement of government" and for his service as chairman of the Professional Association for Civic Education (PACE), 1969–1972.

The award also cited Dr. Kief "for his determined leadership in helping physicians to take a more active role in governmental affairs and to achieve a better understanding of important political issues with a view to assuring the people of Wisconsin that laws affecting their health will be just and proper for the good of all."

Dr. Kief was president of the State Medical Society, 1967–1968 and this month was reelected as an alternate delegate of the State Medical Society to the American Medical Association. He has served on the State Health and Social Services Board since its formation in 1967 and is currently vice-chairman of that board. He is health officer for the city of Fond du Lac.

Dr. Kief

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MANAGING EDITOR: Eorl R. Thoyer, Secretary, Stote Medicol Society of Wisconsin.

Election Results

The House of Delegates elected (or reelected) the following physicians to these positions:

PRESIDENT-ELECT: Dr. Gerald J. Derus, Madison.

VICE-SPEAKER: Dr. W. D. Hamlin, Mineral Point.

COUNCILORS: Drs. John J. Foley, Menomonee Falls; Louis Olsman, Kenosha; Robert Beilman, Madison; T. J. Doyle, Superior, (reelected); T. J. Foley and D. K. Schmidt, Milwaukee (both reelected).

DELEGATES TO AMA: Drs. John M. Bell, Marinette; George E. Collentine, Jr., Milwaukee; Charles J. Picard, Superior (all reelected).

ALTERNATE DELEGATES TO AMA: Drs. Eli M. Dessloch, Prairie du Chien; David J. Carlson, Milwaukee; and Harold J. Kief, Fond du Lac (all reelected).

The Council elected (or reelected) the following physicians to these positions:

CHAIRMAN OF THE COUNCIL: Dr. E. J. Nordby, Madison (reelected).

VICE-CHAIRMAN: Dr. J. E. Dettmann, Green Bay (reelected).

TREASURER OF THE SOCIETY: Dr. F. L. Weston, Madison (reelected).

ASSISTANT TREASURERS serving the Society, SMS Realty Corporation, and Wisconsin Physicians Service: Drs. H. Kent Tenney, N. A. Hill, J. T. Sprague, R. A. Sievert, and A. A. Quisling, Madison (all reelected).

WISCONSIN MEDICAL JOURNAL: Medical Editor, Dr. V. S. Falk, Edgerton (reelected for two years); Editorial Director, Dr. Raymond Headlee, Elm Grove (reelected).

COMMISSION ON STATE DEPARTMENTS: Dr. T. W. Tormey, Jr., Madison, general chairman; and W. J. Egan, Milwaukee, vice-chairman (both reelected). Chairman of divisions of the Commission on State Departments who were reelected are: Drs. Craig Larson, Milwaukee, aging; D. A. Treffert, Fond du Lac, alcoholism and addiction; H. A. Anderson, Madison, chest diseases; Meyer S. Fox, Milwaukee, ear, nose and throat, John J. Suits, Marshfield, handicapped children; F. J. Hofmeister, Wauwatosa, maternal and child welfare; E. E. Houfek, Sheboygan, nervous and mental diseases; P. A. Dudenhoefer, Elm Grove, rehabilitation; J. C. H. Russell, Ft. Atkinson, school health; George Nadeau, Green Bay, vision. (Note: All of the above reelected).

The following physicians were elected (or reelected) to these positions on the Charitable, Educational and Scientific Foundation:

PRESIDENT: Dr. Robert T. Cooney, Portage (reelected).

Dr. Foley

Dr. Olsman

Dr. Beilman

Dr. Nordby

VICE-PRESIDENT: Dr. R. M. Senty, Sheboygan.

TREASURER: Dr. L. C. Pomainville, Wisconsin Rapids (reelected).

TRUSTEES ON EXECUTIVE COMMITTEE: Dr. D. K. Schmidt, Milwaukee, and The Honorable Carl Flom, Madison (reelected) and Dr. E. P. Rohde, Galesville.

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PRESENT FOR OPEN HEARINGS on the future course of the AMA held May 10 in Milwaukee are: (left to right) Members of the AMA Council on Long-Range Planning and Development Donald N. Sweeny, MD, Detroit, Mich.; Richard L. Meiling, MD, Columbus, O. (vice-chairman); John M. Chenault, MD, Decatur, Ala. (chairman); Dale C. Reynolds, MD, Portland, Ore.; and chairman of the Wisconsin AMA delegation, Roman E. Galasinski, MD, Milwaukee.

HEARING: AMA

continued from page 29

- Become a strictly scientific education organization and set up a distinct group for legislative lobbying.
- Support a proposal that doctors give free medical care for needy persons over 65 and the poor.
- Be more vigorous in opposing environmental health problems and boycott products of businesses and industry which cause pollution.
- Develop its own blueprint for changes in the health system for the years ahead.
- Formally oppose the Vietnam War as being "unhealthy."

E. J. Nordby, MD, chairman of the State Medical Society's Council, said in his testimony that the AMA should constantly seek new blood for its leadership positions. He said the Council was dismayed over the growing importance that "seems to be placed on electioneering and campaigning for high office in the AMA." He also said the AMA should respond constructively and strongly to proposals and laws oppressive to doctors.

Dr. Nordby said, however, that "there is much about the AMA that is good. There is more that is outstanding. There is some that is great."

A second hearing was held by the AMA's Council on Long-Range Planning and Development in Rochester May 17–18 in conjunction with the annual meeting of the Minnesota State Medical Association.

The two midwest hearings are a prelude to the first national hearing that the AMA Council will conduct in San Francisco on the day prior to the AMA's 1972 Annual Convention. The AMA Council's guidelines for that hearing allot 10 minutes for each witness and urge prospective witnesses to submit written statements in advance. Witnesses will be scheduled on a first-come, first-serve basis. As directed by the AMA's House of Delegates at the 1971 Clinical Convention, testimony will be confined to four subject areas: proposed changes in AMA's Constitution and Bylaws, AMA's organizational structure, delineation of responsibilities of AMA councils and committees, and other suggestions designed to improve the role of the AMA.

The hearing will be held June 17 from 9 AM to 5 PM in the Imperial Ballroom of the San Francisco Hilton. Written statements should be sent to the Council at AMA headquarters, 535 North Dearborn Street, Chicago, Ill. 60610.

The second national hearing will be November 27, the day prior to the opening of the AMA's 1972 Clinical Convention in Cincinnati. The same guidelines will apply.

The hearings were proposed by Wisconsin's AMA delegation at the last Clinical Convention November 28–December 1 in New Orleans.

Beaumont Award to Boston Surgeon

Dr. Richard H. Egdahl of Boston, Mass., was this year's recipient of the Beaumont Memorial Lecture Award during the State Medical Society's Annual Scientific Meeting in Milwaukee in May.

Dr. Egdahl, professor and chairman of the Department of Surgery, Boston University Medical Center, spoke on "The Diagnosis and Treatment of Hyperparathyroidism." He accepted the award from Dr. Leland C. Pomainville of Wisconsin Rapids, treasurer and a trustee of the Society's Charitable, Educational and Scientific Foundation which administers the memorial fund.

The award is given annually to an outstanding physician in the United States to honor William Beaumont, MD, a pioneer physician whose experiments on the human stomach during military duty at Fort Crawford in Prairie du Chien gained national recognition.

Elvehjem Award to Minnesotan

Dr. A. L. Schroeter of Rochester, Minn., received the Elvehjem Memorial Lecture Award during the 131st annual scientific meeting of the State Medical Society, held at the Marc Plaza in Milwaukee, May 9–11.

Dr. Schroeter, a consultant in dermatology at the Mayo Clinic, spoke on "Epidemiology and Treatment of Gonorrhea." He accepted the award from Dr. D. K. Schmidt, Milwaukee, a member of the Executive Committee of the Society's Charitable, Educational and Scientific Foundation.

The award, administered by the Foundation, honors Conrad A. Elvehjem, an international authority in biochemistry. An eminent teacher and administrator, he served as the 13th president of the University of Wisconsin.

Pictures of the presentations of the two above awards appear on page 36c.

Task Force Chairman's "Recklessness" Negates Value, Dr. Purtell Declares

In his speech to the opening session of the House of Delegates, incoming State Medical Society president, Dr. Robert F. Purtell, responded to a call for a public utility approach to health care made recently by David Carley, chairman of the Governor's Task Force on Health Planning and Policy.

Dr. Purtell said Mr. Carley, "gave vent to a display of recklessness when he called for legislation putting health care of this State under licensing and control before the Task Force had even had an opportunity to consider it. I think he has negated any value he might have had as chairman of the Task Force."

Dr. Purtell said, "It would be ridiculous to believe that there is no room for improvement. If there is not room for improvement, we have reached a stalemate in medicine."

In particular, he said, physicians should "always keep before us the plight of the poor. It is one thing to be sick or injured. It is a double calamity to be sick and injured and poverty stricken. After 40 years in the practice of medicine, I am convinced that we will always have the poor in our care. I believe that for these people we should reserve our most tender care."

The full text of his message will appear in the June issue of the *Wisconsin Medical Journal.*

The new president appointed 31 state physicians to six society committees as one of his initial acts in office.

Those appointments (or reappointments) are as follows:

Committee on Cancer: Drs. Richard F. Sorensen, West Bend; Robert E. Carlovsky, Fond du Lac; Thomas A. Schroeder, Oconomowoc; Clarence M. Scott, Superior (reappointment); and Dr. John K. Scott, Madison, reappointed chairman.

Committee on Grievances: Drs. Gerald C. Kempthorne, Spring Green; Brian T. Coffey, Racine; Henry S. Ashe, Minocqua; Elwood W. Mason, Milwaukee, reappointed chairman, and Dr. Ashe appointed vice-chairman.

Commission on Public Policy: Drs. Thomas P. Belson, Waukesha; Martin L. Janssen, Adams; Theodore C. Fox, Antigo; Patrick J. Bates, Eau Claire; Raymond E. Skupniewicz, Racine; William G. Richards, Beaver Dam (Section on Pathology); Thomas L. Carter, Madison (Section on Radiology); John U. Peters, Fond du Lac (Section on General Practice); George M. Shinners, Green Bay (Section on Public Health); reappointed Dr. Roger Laubenheimer, Milwaukee (Section on Dermatology); and Dr. William T. Russell, Sun Prairie, reappointed chairman.

Commission on Health Information: Drs. Robert M. Senty, Sheboygan; James L. Nolan, Jr., Waukesha; Richard W. Shropshire, Madison; and Robert G. Hansel, Baraboo, reappointed chairman.

Commission on Hospital Relations and Medical Education: Drs. Larry W. Johnson, Lancaster; Douglas D. Klink, Milwaukee; John William Boren, Jr., Marinette; and Dale V. Moen, Shell Lake, reappointed chairman.

Commission on Scientific Medicine: Drs. Bradley G. Garber, Osseo; Martin Z. Fruchtman, Waukesha. (This commission selects its own chairman.)

1973 Annual Meet in March

A recommendation by the State Medical Society's Council that the next annual meeting be held March 25–26–27 in Milwaukee was approved by the House of Delegates. It was felt that there would be fewer conflicts at this time than at the traditional May meeting date.

Houghton Award Presented Two Medical Students

A senior medical student from each of Wisconsin's two medical schools received the J. H. and W. J. Houghton, MDs Award at the State Medical Society's 1972 awards program May 7 in Milwaukee.

Eliot J. Huxley of the University of Wisconsin Medical School and James B. Johnson of the Medical College of Wisconsin were presented the award by Robert T. Cooney, MD, president of the Society's Charitable, Educational and Scientific Foundation which administers the memorial fund.

Dr. Huxley will intern at Parland Memorial Hospital, Dallas, Texas, following graduation; Dr. Johnson has a medical internship at Presbyterian Hospital, Philadelphia.

The award consists of $100 to each recipient and an inscribed plaque. It is granted annually to "one or more students who, through scholastic excellence, extracurricular achievement and interest in medical organization, show high promise of becoming a complete physician."

HOUGHTON AWARD RECIPIENTS Eliot J. Huxley, Madison (left) and James B. Johnson, Milwaukee (center) are shown with their wives and Dr. Robert T. Cooney, Portage, who presented the awards.

The award was named after the late John H. Houghton, MD, Wisconsin Dells, and William J. Houghton, MD, Milwaukee, brothers who were councilors of the State Medical Society.

Before their deaths, the Doctors Houghton jointly endowed the award for medical students. Their hope was that the distinction would encourage young men and women "to a greater appreciation of the need for physicians to work together in their county, state and national medical organizations and to achieve a well-rounded education including the socio–economic as well as the scientific."

THIS ISSUE of the Green Sheet replaces the formal printing of Reports and Proceedings of the Annual Session of the House of Delegates, May 8–10, 1972, due to the great expense involved. Members of the Society may, upon request, study the Official Transcript of the meeting at the State Medical Society Headquarters in Madison.

The House deliberated 25 resolutions submitted by county medical societies and one section (names included in parentheses below), as well as reports of officers, the Council, committees, commissions, and divisions of the Society, many of which were digested in the April GREEN SHEET. Following is a summary of actions taken on recommendations of the four reference committees:

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● PRESIDENT'S REPORT—The House commended President Behnke for the leadership and spirit of optimism which he brought to the Society during his term as President.

● PRESIDENT-ELECT'S REPORT—Accepted the report of President-elect Purtell (which will appear in full in the June issue) and concurred with his belief that physicians must become increasingly active in the continuing deliberations concerning medical care and health.

● SECRETARY'S REPORT—Accepted the report of Secretary Thayer and commended him for the improved dialogue his office has developed between members of the Society, its officers, committees, and staff.

● REPORT OF AMA DELEGATION—Commended the AMA delegation's activities as reported by R. E. Galasinski, MD, chairman, relative to action taken which has led the AMA to provide a forum for physicians to express their views and concerns. (See report on AMA Long-Range Planning and Development hearing elsewhere in this issue of the GREEN SHEET.)

● AD HOC COMMITTEE ON SECTION REPRESENTATION—Adopted the recommendation of the committee that scientific sections continue to have voting representatives in the House of Delegates.

● COUNCIL COMMITTEE ON ECONOMIC MEDICINE—Adopted its report and concurred with the recommendation that it would not be in the best interest of the total membership *at this time* to sponsor or implement any one program of professional liability insurance. The House also agreed that additional information on other Society-sponsored protection programs be made available through the GREEN SHEETS; i.e., group life, office overhead, disability, WPS–Blue Shield, and group annuity.

● COMMISSION ON STATE DEPARTMENTS—The House took the following actions on reports of nine of its ten divisions:

Aging: Concurred with all of the divisions recommendations, including support for property tax relief based on need for all Wisconsin senior citizens and that physicians seek representation on housing development authorities; and that the Auxiliary strengthen its programs for services to the elderly.

Alcoholism and Addiction: Approved the report and recommendations that (1) if an individual practitioner desires to become involved with methadone maintenance, he should do so through an established FDA program and that physicians should voluntarily restrict prescription of amphetamines; and (2) the Society support the enactment of the Uniform Controlled Substance Act in Wisconsin, but should not at this time adopt a position on the proposal that all medicines containing codeine be on a prescription basis.

Ear, Nose and Throat: Adopted the recommendation that the Society aid in developing a list of physicians to act as consultants to the Department of Industry, Labor, and Human Relations under the new Occupational Noise Exposure Code.

Handicapped Children: Endorsed the recommendation that the Wisconsin Bureau of Handicapped Children provide payment to board eligible oral surgeons for professional services.

Maternal and Child Welfare: Concurred with the reports of the Division on Maternal and Child Welfare and its Maternal Mortality Study Committee, including the recommendation that all matters relating to obstetrics and pediatric care should be considered by these committees before the adoption of official Society position; also urged that all Wisconsin insurance carriers provide health care benefits for the newborn effective at birth. (See Report of Reference Committee on Finances on Resolution L.)

Nervous and Mental Diseases and Rehabilitation: Accepted the reports of these divisions with appreciation.

School Health: Adopted the report including recommendations that the "Days Out" regulations of the Wisconsin Interscholastic Athletic Association be part of the playing rules rather than the insurance benefit structure, and accepted the policy on administering medications in schools which accompanied the report; encouraged all state colleges and universities to use the uniform physical examination form as previously published in the WISCONSIN MEDICAL JOURNAL; agreed that physical examinations for athletes should continue to be required on a yearly basis.

Vision: Accepted the recommendation that the Society continue to support legislation requiring safety glasses in certain academic classes, and the division's program plans being developed with the Wisconsin Education Association.

● COMMITTEE ON MEDICINE AND RELIGION—Accepted its report for information.

● COMMITTEE ON MILITARY MEDICAL SERVICE—Accepted its report for information.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Doctors D. J. Carlson, Milwaukee (chairman); J. T. Murphy, La Crosse; Robert Bein, Racine; P. J. Stuff, Bonduel; F. A. Karsten, Horicon.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Doctors D. F. Ruf, Darlington; J. K. Scott, Madison (chairman); P. W. Wallestad, Port Washington; J. R. O'Connell, Milwaukee; I. A. Galarnyk, Plain.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● COMMISSION ON PUBLIC POLICY—Accepted the report of the Commission on Public Policy and commended its chairman and members; urged that delegates relate contents of the report to their constituents.

● LEGISLATIVE ACTIVITIES—Adopted Resolutions C (Waukesha) and I (Outagamie) and noted that the Society's Constitution and Bylaws already require that county societies appoint an auxiliary committee on public policy and that the Commission on Public Policy is attempting to coordinate county and state legislative activities. The House also emphasized the need for county societies to promote legislative action.

● ACCREDITATION—Adopted Resolution F (Barron–Washburn–Sawyer–Burnett) calling for the introduction of legislation which would provide that all individuals professing to deliver primary health care must graduate from a school accredited by an agency recognized and approved by the United States Office of Education, and referred it to the Council for implementation. Resolution T (Trempealeau–Jackson–Buffalo) on the same subject was not adopted as testimony indicated that its intent was covered by Resolution F.

● COMMISSION ON SAFE TRANSPORTATION—The House concurred in its recommendations that the Society favor (1) upgrading ambulance operations and standards for ambulance personnel; (2) adoption of a 0.10 level for determination of alcohol impairment for driving; (3) the required use of seat belts on school buses; (4) the creation of an official Medical Advisory Board to the Wisconsin Division of Motor Vehicles; and (5) the adoption of the Interstate Commerce Commission physical standards for school bus operators as minimum guidelines.

The House also took note of a new Wisconsin law requiring the establishment of county highway safety commissions and recommended that county medical societies seek active physician representation.

● DRUNKEN DRIVING—The House adopted the following substitute for Resolution H (La Crosse):

> *Resolved,* That the State Medical Society of Wisconsin support the adoption of a 0.10 level for determination of alcohol impairment for driving and individuals driving with this blood level of alcohol should automatically have their licenses suspended for 6 months; and be it further
>
> *Resolved,* That at the time of a second conviction, an individual must enroll in an active Alcoholic Rehabilitation Program or have his license suspended until such time as he does so enroll.

● COMMISSION ON SCIENTIFIC MEDICINE—The House adopted the following recommendations: (1) that Society funds be specifically budgeted and allocated for postgraduate education; (2) the annual scientific session be reduced to two days; (3) continue the present format consisting of a plenary session each morning with one or more specialty section programs in the afternoon; (4) rescind Chapter II, Section 2, of the Bylaws granting the WISCONSIN MEDICAL JOURNAL first opportunity to publish scientific papers presented at the annual meeting.

● COMMITTEE ON CANCER—Adopted its recommendation encouraging the various clinical and laboratory research programs engaged in studies of cancer; also supported the establishment of tumor registries along the lines of the Cancer Review and Emendation Program (CARE) of the University of

Wisconsin Medical Center; and reminds all Wisconsin physicians that cancer is a reportable disease.

● COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—Accepted its report and adopted a resolution stating that "Wisconsin hospitals be encouraged to continue to provide education for nurses at the diploma level, and in instances where this has been discontinued in favor of a licensed practical nurse program or an associate degree program, consideration be given to reinstituting the three-year diploma program."

● COMMITTEE ON OCCUPATIONAL HEALTH of the Commission on Health Information—The House went on record encouraging all county societies to make certain that they form occupational health committees to give advice on the new Occupational Safety and Health Act.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● REDISTRICTING—The House adopted the following substitute for Resolution D (Waukesha):

Resolved, That the President of this Society be instructed to appoint immediately an ad hoc committee with statewide representation to review the present districting of the State Medical Society of Wisconsin; and be it further

Resolved, That the ad hoc committee make its recommendations to the Council within six (6) months following adoption of this resolution so that appropriate action can be taken by the House of Delegates no later than May, 1973.

● ANNUAL MEETING—Resolution E (Waukesha) was rejected because the Council had already appointed an ad hoc committee on the annual meeting which is continuing its study.

● AMA MEMBERSHIP—Resolutions J (Dane) and K (Lafayette) were rejected with the House stating its belief that the physicians of Wisconsin should continue to present a united front through unified membership in the county and state societies and the American Medical Association.

● COMPREHENSIVE HEALTH PLANNING—The House adopted Resolution M (Milwaukee) calling for a Society-sponsored meeting for physicians participating in local comprehensive health planning agencies.

● ORGANIZATION AND FUNCTION OF THE AMA—The House did not adopt Resolution R (Green) because the AMA Council on Long-Range Planning and Development, as a result of an AMA resolution introduced by the Wisconsin delegation, had already scheduled hearings designed to accomplish the intent of this resolution.

● 1975 ANNUAL MEETING—Adopted Resolution V (Dane) and accepted with thanks the invitation of the Dane County Medical Society to meet in Madison in 1975.

● SUBMISSION OF RESOLUTIONS TO SMS—The House adopted the following substitute for Resolutions W and X (Fond du Lac):

Resolved, That resolutions to the annual meeting of the State Medical Society must be submitted no later than two months prior to the annual meeting and be sent to the delegates no later than six weeks prior to the annual meeting: and be it further

Resolved, That summaries of all resolutions be printed in the WISCONSIN MEDICAL JOURNAL GREEN SHEET prior to the annual meeting.

It further adopted an amendment to Chapter III, Section 9, of the Bylaws, which presently requires submission of resolutions 30 days before the first session of the House, to effect this change.

● SUBMISSION OF RESOLUTIONS TO THE AMA—The House adopted the following substitute for Resolution Y (Fond du Lac):

Resolved, That resolutions to the AMA be submitted in sufficient time prior to each annual and clinical meeting so that summaries of all resolutions can be published in JAMA or the AMERICAN MEDICAL NEWS one month prior to the annual and clinical meeting.

● COUNCIL REPORTS—Report No. 12 and the supplementary report of the Council included information on the Ad Hoc Committee on the Annual Meeting, the Special Committee on the Shortage of Physi-

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Doctors W. E. Wright, Mondovi; J. M. Jauquet, Ashland; W. E. Finlayson, Milwaukee (chairman); R. A. Starr, Viroqua; and J. R. McKenzie, Jr., Oshkosh.

cians, the Ad Hoc Committee on Chiropractic, Wisconsin Health Care Review, Inc., as well as numerous other ongoing Society projects. These informational reports as accepted by the House also included a number of recommendations for current and long-range goals:

(1) Encourage greater involvement by members in the structured affairs of the Society, especially in areas affecting health care delivery and legislation.

(2) Solicit and promote the active cooperation of each county medical society with the State Society's Committee on Peer Review and with Wisconsin Health Care Review, Inc. to assure success to this Wisconsin version of a peer review "foundation."

(3) Revamp and revitalize the legislative and civic education activities of the State Medical Society and the county medical societies to directly involve the personal participation of many more physicians and Auxiliary members.

(4) Foster information programs for members to acquaint them with services available to them through the State Medical Society.

(5) Cooperate with Wisconsin's AMA delegates to select and develop Wisconsin members for service at all levels of AMA activity.

(6) Utilize boldness, tact and diplomacy in conveying to governmental agencies, third party carriers, and the public a clear understanding of what the practicing physicians of Wisconsin stand for and what they will not stand for.

(7) Maintain a close liaison with the Governor's Health Planning and Policy Task Force which is scheduled to complete its studies and recommendations by December 31, 1972. Major changes in health policy are being contemplated by the Task Force, including creation of a public utility for health care and a statewide, state-supervised health insurance plan of some type, to name but two. The Task Force's recommendations will undoubtedly call for Society reaction and the Council is prepared to provide it forcefully, but constructively, and if necessary bring some matters to the House of Delegates for policy declaration.

● PEER REVIEW—The House also accepted the report of the Council's Committee on Peer Review and urged that county societies give full endorsement and support to this activity.

● COMMISSION ON HEALTH AND NATURAL RESOURCES—Received the report and agreed with the Council that membership dollars should not be used for a proposed experiment to test swimming water, sewer discharges into Lake Mendota, and infections found in children in a Madison area which houses principally University of Wisconsin faculty and students and their families. This was referred to the CES Foundation for possible funding and the balance of the report accepted.

● CONSTITUTIONAL AMENDMENTS—The following constitutional amendments were officially received for action at the 1973 annual session:

Society's Purpose Clause: Amend Article II entitled "Purpose" as follows:

In the first and second lines of Article II delete the words "federate and"

In the tenth line delete "to promote friendly intercourse" and substitute "to promote open communication and understanding"

Election of Councilors: Amend Article IX entitled "Officers" as follows:

Delete the second paragraph which now reads: "Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated." Re-create the second paragraph of Article IX to read: "Each councilor shall be nominated and elected only by the elected delegates of the county medical society or societies for the councilor district in which he has his principal place of practice. Such election shall be subject to the confirmation of the House of Delegates."

DR. ALBERT POPP, MILWAUKEE (left) received a special award from the State Medical Society's Charitable, Educational and Scientific Foundation during the Annual Meeting in Milwaukee. Dr. Robert Cooney, Portage (right), the Foundation's president, presented the award recognizing the over $15,000 loaned to 27 medical students since the Popp Student Loan Fund was established in 1964. The Foundation administers the fund.

OTTO A. MORTENSEN, MD, Madison (left), long-time University of Wisconsin anatomy professor, received a medical teaching award May 7 at the State Medical Society's 1972 awards program. Presenting the award is (right) Dr. N. A. Hill, Madison, on behalf of the Interstate Postgraduate Medical Association. It cited Doctor Mortensen for his teaching, his leadership in the medical school and his generosity with his "time and talents to better medical education and by so doing to improve the quality of health care in our state."

REFERENCE COMMITTEE ON FINANCES—Doctors J. E. Taxman, Milwaukee; W. G. Kendell, Fond du Lac; Thomas E. Dugan, Waukesha (chairman); P. G. LaBissoniere, Wauwatosa; and L. W. Chosy, Madison.

● MEMBERSHIP OF COMMISSION ON SCIENTIFIC MEDICINE—The House amended Chapter VII, Section 2, of the Bylaws as follows:

Repealed the first two sentences and re-created them to read:

"The Commission on Scientific Medicine shall consist of nine appointed members, the deans of the two medical schools in Wisconsin, and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve a term of three years, and initial terms shall be staggered so that the terms of one third of the appointed members shall expire each year."

REFERENCE COMMITTEE ON FINANCES

● MEDICARE—The House did not adopt Resolution A (Rock) which called for an insert statement to Medicare-eligible patients regarding usual, customary and reasonable charges. It was the feeling of the House that direct communication between physician and patient would be more workable and that the Commission on Medical Care Plans should prepare a brochure that gives appropriate information regarding the Medicare allowances for distribution to patients at the time of service.

WALTER ZEIT, PhD, Milwaukee (left), emeritus professor of anatomy at the Medical College of Wisconsin, received the State Medical Society's Distinguished Service Award at the awards program during the May Annual Meeting. Presenting the award is (right) Dr. E. J. Nordby, Madison, chairman of the Society's Council. The award recognizes Doctor Zeit's over 50 years of service in teaching and administration at the Medical College (formerly Marquette School of Medicine). Although formally retired, Doctor Zeit still carries a teaching load at the school.

● UNIFORM FEE SCHEDULE—The House considered Resolutions B (Eau Claire–Dunn–Pepin), O (Juneau) and U (Trempealeau–Jackson–Buffalo), all three of which dealt with the establishment of fixed or uniform fees. They were not adopted for the following stated reasons: (1) they pose a danger of price fixing; (2) eliminate the basic principles of "customary, usual and reasonable"; and (3) ignore the realities of the local economics of medical practice.

County societies were, however, urged to maintain appropriate and realistic customary, usual and reasonable fees.

● PHASE II—Resolution G (Pierce–St. Croix) calling for the Society to make a test case of current Phase II regulations was not adopted because the AMA is providing supporting advice on such a test suit in the State of Florida.

● FIRST DAY HEALTH INSURANCE COVERAGE FOR INFANTS—Adopted Resolution L (Section on Pediatrics) and instructed the Commission on Medical Care Plans to implement the intent of this resolution through appropriate communication with the health insurance industry in Wisconsin.

● MANDATORY VISITS TO EXTENDED CARE FACILITIES—Adopted Resolution N (Kenosha) because it re-emphasized action taken at last year's annual session on this subject.

● PAYMENT CRITERIA OF SURGICAL CARE–BLUE SHIELD—Did not adopt Resolution P (Lincoln) but suggested that county medical societies individually negotiate any points of difference they may have with insurance carriers.

● CHIROPRACTIC: SPECIAL ASSESSMENT—Resolution Q (Dodge). The House affirmed its agreement with proposed efforts to oppose the expansion of the cult of chiropractic and determined that additional funds are necessary to continue this effort which will emphasize public education, and adopted a one-time special assessment of $10 effective now.

● Creation of age-exempt membership category—The House rejected Resolution S (Brown), which would permit waiver of dues at age 70, because of its fiscal impact.

● Commission on medical care plans—Accepted the report of the Commission and commended its members and staff for administration of a fiscally sound and innovative plan.

Benefits for Alcoholism: In addition, the House accepted a report from the Commission on benefits for alcoholism and noted that WPS-Blue Shield has expanded its benefits in both general hospitals and alcohol treatment centers, and that it will consider further expansion of benefits for alcoholism and other addiction.

Procedure Coding Systems: The House accepted another report from the Commission on procedure coding systems, concluding that the 1964 California Relative Value Scale should be continued in use until a new coding system is agreed upon nationally.

● 1972 Budget; Report of the treasurer; dues for 1973—The House accepted the report of Treasurer Weston with commendation, expressed its appreciation to Doctor Dettmann, chairman of the Finance Committee of the Council, and directed that dues not be changed for 1973.

Council Adopts Resolutions in Memory of State Leaders

Whereas, Edward J. Logan was a man of great personal quality, recognizing his responsibilities as administrator of a major hospital, as a citizen of the community in which he lived and worked, and as a leader in health care for the people of Wisconsin; and

Whereas, Largely through his efforts and leadership Milwaukee Children's Hospital was presented the State Medical Society's Community Achievement Award in 1960; and

Whereas, His outstanding contributions and services to the people of Wisconsin were recognized by his election as President of the Wisconsin Hospital Association in 1968 and by the many other offices and advisory posts he held with other organizations in the health field; and

Whereas, His many friends were deeply saddened by his untimely death on February 22, 1972; therefore be it

Resolved, That the Council of the State Medical Society of Wisconsin by its adoption of this resolution this seventh day of May, 1972, give appropriate recognition to the exemplary life of Edward J. Logan and pause in tribute and respect to his memory.

* * *

Whereas, The Council of the State Medical Society and the Charitable, Educational and Scientific Foundation were saddened by the death on May 3, 1972 of Mr. Edwin E. Bryant of Stoughton, Wisconsin, who worked with and for this Society as a member of the Commission on Medical Care Plans and the Charitable, Educational and Scientific Foundation, and

DR. JOHN M. BELL, Marinette, left, was presented the State Medical Society of Wisconsin's first Civic Leadership Award at the Society's annual meeting in Milwaukee. At right, presenting the award, is Dr. E. J. Nordby, Madison, chairman of the Society's Council. Dr. Bell was cited for his many civic, medical society, church and business contributions.

DR. A. L. SCHROETER (left) of Rochester, Minn., is shown receiving the Elvehjem Memorial Award from Dr. D. K. Schmidt, Milwaukee.

DR. RICHARD H. EGDAHL (right) of Boston, Mass., receiving the William Beaumont Memorial Lecture Award from Dr. Leland C. Pomainville of Wisconsin Rapids.

Whereas, His busy life as a prominent industrialist was filled even more with civic activity and personal generosity to his many interests throughout the state; therefore be it

Resolved, That the Council pay tribute to E. E. Bryant—a nonmedical leader among physicians.

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E. Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1971. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., Student Loan Fund, and Employees' Pension Plan and Trust Agreement. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin

BALANCE SHEET

December 31, 1971

ASSETS

Current Assets		
Cash		$ 43,696.95
Accounts Receivable—General		9,101.58
Due from Employees		1,024.23
Due from Charitable, Educational and Scientific Foundation Incorporated		5,552.70
Due from SMS Realty Corporation		11,966.03
Due from Wisconsin Medical Journal	$44,652.67	
Investment in Wisconsin Medical Journal (Deficit)	(31,474.33)	13,178.34
Due from Wisconsin Physicians Service		8,635.63
Due from Employees Pension Plan		936.99
Due from Other Divisions for Accrued Vacation Pay		115,425.90
Commercial Bonds		99,187.50
Common Stock		8,361.52
Dividends Receivable		30.75
Accrued Interest Receivable		148.96
Guarantee Deposit		425.00
Unexpired Insurance		33.48
Total Current Assets		$317,705.56
Fixed Assets		
Furniture and Equipment	$39,372.36	
Less: Accumulated Depreciation	32,867.17	
Total Fixed Assets		6,505.19
Prepaid Expenses and Deferred Charges		
Prepaid Postage and Deposits	$ 8,825.83	
Inventory of Forms and Office Supplies	8,040.96	
Other Deferred Expense	4,181.21	
Total Prepaid Expenses and Deferred Charges		21,048.00
TOTAL ASSETS		$345,258.75

LIABILITIES AND CAPITAL

Current Liabilities		
Accounts Payable		$ 33,103.70
Dues Held for Section on Ophthalmology		11,089.94
Accrued Payroll Taxes		19,495.93
Other Payroll Deductions		4,476.91
Accrued Employee Pension Plan Contributions		280.61
Accrued Property Taxes		13,485.89
Accrued Vacation Pay		123,514.30
Total Current Liabilities		$205,447.28
Deferred Income		
Prepaid Membership Dues	$57,798.75	
Other Prepaid Income	7,541.50	
Total Deferred Income		65,340.25
TOTAL LIABILITIES		$270,787.53

NET WORTH

Capital of General Fund 1/1/71	$39,536.70	
Excess—Income Over Expense 1971	43,450.86	
Increase (Decrease) in Capital Invested in Wisconsin Medical Journal	(8,516.34)	
TOTAL CAPITAL 12/31/71		74,471.22
TOTAL LIABILITIES AND CAPITAL		$345,258.75

NOTES:

(1) Reserves of Wisconsin Physicians Service, a Division of the State Medical Society of Wisconsin, are not included in this statement.

(2) The interest in SMS Realty Corporation is not carried as an asset of the General Fund.

STATE MEDICAL SOCIETY OF WISCONSIN
General Fund
Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1971

INCOME

Members 1971 Dues		$557,499.00
Less: Allocation to Wisconsin Medical Journal		19,335.00
Subtotal		$538,164.00
Member Dues—Prior Years		1,740.00
Dues—Academy of Medical History		1,135.00
Annual Meeting		20,780.70
Administrative Services		6,811.00
Miscellaneous Income		757.31
Income on Funds Invested		6,357.48
Gain on Sale of Securities		1.70
Gain on Sale of Fixed Assets		350.00
TOTAL INCOME		$576,097.19

EXPENSES

Payroll	$194,698.93	
Payroll Related Costs	32,429.66	
President and President Elect Expenses	4,810.34	
AMA Annual, Clinical and Special Meetings	10,800.00	
Conference Expenses	18,706.07	
Association Dues	2,624.73	
Staff Travel	19,195.87	
Telephone	8,923.75	
Resource Material	1,425.41	
Printing and Forms	16,466.07	
Postage	15,943.88	
Office Supplies	3,194.12	
Promotion	2,116.82	
Insurance—General	3,418.89	
Grants and Appropriations	17,965.00	
Cafeteria Expense	2,233.86	
Speakers Expense	3,259.76	
Outside Services	29,026.99	
Miscellaneous Expense	2,972.01	
Auditing and Accounting Services	3,816.50	
Legal Counsel	32,935.55	
SMS Legislative Retainer	14,300.00	
Consultation Services	6,000.00	
Depreciation	2,749.20	
Rent—Central Office	49,263.54	
Rental of Equipment	2,974.57	
Equipment Repair and Maintenance	565.16	
Personal Property Tax	917.04	
Christmas Card Expense	2,759.64	
Total	$506,493.36	
Less: Portion of Above Expenses Recovered by Services Furnished to Others	4,855.06	
TOTAL EXPENSES		501,638.30
Excess—Income Over Expenses before Expenses Relating to Prior Years		$ 74,458.89
Prior Years Expenses		
Pension Plan Expense Relating to Prior Years	$ 2,919.63	
Vacation Pay Relating to Prior Years	8,088.40	
Write Off of Notes Receivable	20,000.00	
Total Prior Years Expenses		31,008.03
Excess—Income over Expenses		$ 43,450.86

NOTE:

The above excess of income over expense for 1971 is closed to the net worth accounts as follows:

To Capital Surplus	($ 1,436.52)
To Unappropriated Surplus	44,239.69
Total—General	$ 42,803.17
To Academy of Medical History	647.69
Total	$ 43,450.86

COUNCIL MINUTES—State Medical Society of Wisconsin

MADISON, FEBRUARY 26–27, 1972

1. Call to Order and Roll Call

The meeting was called to order at 2:00 pm on Saturday, Feb. 26, 1972, at the State Medical Society.

Voting members present: Doctors Schrank, Nordby, Edwards, Smejkal, Dettmann, Rohde, Heinen, Lewis, Manz, Doyle, Egan, LaBissoniere, Schmidt; Past President McRoberts, Speaker Nereim. Present Saturday only: Doctors Galgano, Huth, Davenport, Foley.

Others present: President-elect Purtell, Vice-Speaker Hamlin. Saturday only: Doctors Bell, Collentine, Galasinski, Picard, Carlson, Twelmeyer, Kief, Russell, Simenstad, Headlee; Doctor Biek, State Division of Health; Drs. Robert McMahon and Marc Hansen, Governor's Health Planning and Policy Task Force.

Staff and consultants: Messrs. Thayer, Koenig, Maroney, Reynolds, Brower, Johnson, LaBissoniere; Mrs. Anderson; Misses Cordts and Pyre. Saturday only: Mrs. Davenport; Messrs. Tiffany, Murphy, Kluwin.

2. Special Order: Governor's Health Planning and Policy Task Force

A. Personal Health Services Work Group

Doctor Hansen provided background information on the relationship between the Health Planning and Policy Task Force under the chairmanship of Mr. David Carley, and the Health Policy and Program Council chaired by Ben Lawton, MD.

Doctor McMahon discussed the role of the Personal Health Services work group of the Task Force, of which he is chairman, and asked that councilors return the questionnaire sent them earlier. He said the group is especially interested in reliable information on the number of physicians needed in the state.

B. Additional Activities of Task Force

Mr. Thayer read a statement of principle adopted the day before by the Task Force as a whole, intended as a guide for the balance of its activity. He felt it implied that a legislative approach would be used to resolve many of the problems in health care, though not necessarily all.

He also reported that the Task Force chairman had appointed a special committee to study chiropractic.

3. Approval of Minutes

On motion of Doctors Edwards–Lewis, carried, the Council approved the minutes of its Nov. 18, 1971, meeting.

4. 1972 Annual Meeting

The Council was provided with a schedule of events including business sessions, scientific programs, and related affairs.

There were no nominees for the Council Award in 1972.

On motion of Doctors Dettmann–Schmidt, carried, the Council unanimously approved the nomination of a candidate for the Presidential Citation for Doctor Behnke's consideration.

Mr. Thayer asked councilors to advise the office of their plans for district meetings starting in April. Doctor Nordby asked councilors to urge their constituents to get resolutions in by or before the deadline, and reminded them of the recommendation a year ago that henceforth late resolutions will be forwarded to the House by the Council only if they involve an urgent proposal.

5. Report of Commission on Medical Care Plans

A. Health Maintenance Organization

The Council had referred to the Commission in May 1971 for analysis and recommendation, the question of establishing a structure for a health maintenance organization to be utilized when it becomes necessary. The following recommendation was received by the Council: "HMO developments on the national scene have not materialized as rapidly as many expected. While a variety of legislation has been proposed, none has been enacted. The HMO concept has been explored in depth at numerous meetings, conferences and seminars attended by Commission members and WPS staff. The first experiment at Wild Rose has matured, and others are in various stages of organization.

"From these experiences in HMO theory and practice it seems clear that the core of the HMO concept lies in *performance criteria* rather than in *organization structure*. It appears that diversity, rather than uniformity, among sponsoring organizations is desired by those promoting the HMO. Based upon this background, the Commission on Medical Care Plans recommends that:

"1. This Commission assume ongoing responsibility for HMO and related activities, as the performance criteria are closely related to activities under Commission direction, and

"2. Existing organizational structures be utilized for HMO and related matters, as no unique organizational requirements seem present at this time.

"In the event of significant changes in the emerging HMO scene which make these recommendations inappropriate, the guidance of the Council will be sought."

B. Health Care Financing in Wisconsin

The Council had received prior to the meeting a report from the Executive Committee of the Commission containing several suggestions of innovative proposals it recommended be made to the Governor, his health care Task Force, and the Legislature, on financing mechanisms to provide health care benefits for persons or areas of service not now covered by health insurance.

Part one was a proposal for extending coverage to the unemployed and "uninsurable." Part two involved a proposal for state financing of health care services not generally included in third party financing; i.e., office and outpatient care which is usually the patient's point of entry into the health care delivery system and for the most part patient-financed.

Mr. Tiffany discussed the proposals in terms of an assignment given the staff and consultants by the Commission, in view of the reputation of WPS historically for innovation, to develop some ideas for the Governor's Task Force in its study of health care financing; also because there is almost certain to be more government involvement in health care financing at the state and national level.

There was considerable discussion and suggestions that the proposals receive further study or be held for action by the House of Delegates, although the timeliness of making them known without delay was pointed out.

Doctor Edwards moved that part one be put into appropriate form for submission to the Governor, the Task Force, and the Legislature, and then be cleared with the Executive Committees of the Council and of the

Commission; and that part two be further developed and submitted to the House of Delegates. The motion was seconded, put to vote, and lost.

On motion of Doctors McRoberts–Egan, carried, the entire matter was returned to the Commission for further discussion in cooperation with the full Council, a special meeting being held for that purpose if necessary.

At the Sunday morning session of the Council, Doctor Smejkal moved for reconsideration of this action as regards part one, seconded by Doctor Lewis and carried.

Doctor Nordby informed the Council that since Mr. Murphy had raised a question on Saturday in reference to the proposed method of financing insurance for the unemployed and uninsurable, the Executive Committee of the Commission had been contacted and agreed that it was interested only in promoting the concept and was willing to delete any recommendation on financing since this would be the decision of state government in any event.

On motion of Doctors Smejkal–Edwards, carried, the Council voted in favor of presenting this type of insurance mechanism for the unemployed and uninsurable.

6. Chiropractic

The Council reviewed positive anti-chiropractic activities undertaken by the Society in the past year, and acted on the following recommendations from the Commission on Public Policy which had recently considered the subject:

A. Ad Hoc Committee on Chiropractic

On motion of Doctors Egan–Heinen, carried, the Council authorized appointment of an ad hoc committee on chiropractic, to be composed of members who are or will become expert on the subject and be advisory to the Commission on Public Policy and the Council, the Legislature, and the special Task Force committee to study chiropractic.

B. Use of Title "Dr."

On motion of Doctors Smejkal–Rohde, carried, the Council asked that the Society register a protest with appropriate state officials on the illegal use of the Title "Dr." on Workmen's Compensation panels listing chiropractors.

C. Anti-Quackery Legislation

On motion of Doctors Egan–Edwards, carried, the Council endorsed joint discussions between the Society, the Wisconsin Division of the American Cancer Society, and the Attorney General on the development of an antiquackery law including cancer quackery.

It was generally agreed that the action of the House of Delegates last May which in effect asked for introduction of legislation to outlaw chiropractic in Wisconsin could not be implemented in this session, and this was referred to the ad hoc committee.

7. Status Report on Actions of the House of Delegates in May 1971

The Council had received a written report in July on actions completed or under consideration as of that date. The Secretary reported that since then all actions had been implemented, or were the subject of continuing activity, with four exceptions:

A. Chiropractic legislation referred to above

B. Resolutions G and J relative to nursing education and recruitment

The Commission on Hospital Relations and Medical Education is actively engaged in discussions with nursing representatives on a broad scale, including these resolutions.

C. Professional liability insurance

This study is still under way by the Committee on Economic Medicine, and a progress report has been made to the membership in compliance with Resolution Q.

D. Resolution AA concerning insurance for treatment of alcoholism

The Society has long recommended to commercial insurance carriers that they provide this benefit, and WPS does provide a substantial benefit. It was pointed out that if AB 1348 is enacted by the current Legislature, certain benefits will be required of insurance carriers. The Commission on Medical Care Plans will again consider the subject in March.

8. Legislative Report—Commission on Public Policy

The Council received a current status report on major legislation of interest to the Society. In addition to the recommendations reported above as to chiropractic, Doctor Russell informed the Council that the Commission is continuing efforts to reach agreement with allied health personnel on their objections to the physician's assistant bill. Also, the Commission agreed with the Council's objection to the $10 fee for obstetrical patients to help fund the perinatal health care authority which would be established by SB 597, and suggested such financing be accomplished through general tax funds.

With respect to the position of the Waukesha County Medical Society on the Society's legislative program which had been communicated to individual councilors and others, the Commission on Public Policy agreed that part of the problem may be due to a lack of communicating activities of the Commission and the Society in general, but urged that county medical societies hold meetings with their legislative representatives and take action to appoint county society public policy committees, as required in the bylaws, if they have not done so.

9. Commission on Hospital Relations and Medical Education

Two matters within the jurisdiction of this Commission were reported for Council action:

A. Ninth Federal Reserve District Planning for Nursing Needs and Resources

On motion of Doctors Egan–Edwards, carried, the Council adopted the following resolution:

WHEREAS, Wisconsin is one of the seven states in the upper midwest region which has been designated to cooperate in a proposal to NIH for a study of rural nursing in Wisconsin and the other states, and

WHEREAS, The Commission on Hospital Relations and Medical Education of the State Medical Society of Wisconsin is acting as liaison with the Wisconsin Nurses Association through the Wisconsin Joint Practice Commission, and

WHEREAS, The Commission wishes to have eliminated the barriers which exist between the states which prevent easy transfer of health professionals from state to state within the specified seven state upper midwest region, and

WHEREAS, The Commission continues to urge the supply of more health manpower in Wisconsin and better utilization of the various classifications and categories of health professionals; therefore be it

Resolved, That the State Medical Society of Wisconsin endorse the proposed survey of nursing practice in rural and urban areas of Wisconsin.

B. Broadening the Base of Support for Intern and Residency Programs for Physicians and Hospital-based Nursing Education Programs

On motion of Doctors McRoberts–Lewis, carried, the Council adopted the following statement which in effect puts the Society on record as favoring a change in the way that nursing education and intern and residency programs are funded:

In its position paper on Health Manpower, the State Medical Society of Wisconsin outlined the necessity to increase the numbers of programs providing residency training for physicians and for increasing the numbers of facilities available to train and prepare allied health workers. Thus, the Society is on record to expand training programs for intern and resident physicians, as well as the various levels of nurse preparation programs such as the trained practical nurse, the associate degree nurse, the hospital diploma nurse, and the baccalaureate nurse.

The programs of nursing education seem to be in jeopardy because of difficulties in financing, primarily the three-year diploma programs conducted by several of the major hospitals of Wisconsin. At one time there were more than 20 of these approved schools of nursing; these have now declined to 14. The problem is illustrated by a report from one hospital which had estimated for a student body of 100 members, its three-year diploma nursing program had a net cost of $150,000 during the last year which, when applied to the number of patient days, amounted to more than $2.50 per patient day.

Other questions have been presented to the Commission on Hospital Relations and Medical Education with respect to costs of offering residency training programs. One hospital indicated its cost to provide a postgraduate teaching program for house staff was $500,000–$600,000 for this year. One other hospital was contacted which indicated its cost to provide intern and resident training programs had increased from $24,000 in 1971 to an anticipated cost of $72,000 in 1972. This, however, was due in part to a recent medical school affiliation. A third hospital with a major medical school affiliation estimated a cost of roughly $500,000 per year. This cost included faculty.

A study is presently being conducted by a Wisconsin hospital on a nationwide basis using selected hospitals of comparable size, to determine, if possible, exactly what would be saved if the three-year diploma nursing school program were discontinued.

It becomes apparent that a few hospitals have been burdened with an expense of educating health professionals in certain areas. Further, the cost to the patients in these institutions necessarily has had to be higher than the cost to patients in neighboring institutions without training programs.

Because of the obvious narrow base upon which to draw funds for nursing and medical education, it is strongly urged that the Governor's Health Planning and Policy Task Force, the Governor, the Legislative Council, and members of the Wisconsin Legislature be apprised of the real concern the State Medical Society has that patients in a few institutions not be discriminated against by bearing the full cost of this type of nurse or physician education.

10. Report of AMA Delegation

Doctor Galasinki reported on the resolution successfully introduced by the Wisconsin delegation at the June AMA meeting which settled the debate on the question of a constitutional convention by asking the AMA Council on Long-Range Planning and Development to hold open hearings for all interested members at the next three meetings, with a report to be made in June 1973. In this connection the delegation recommended to the Council that:

A. A hearing for State Society members be held during the Annual Meeting;
B. Members of the AMA Council be invited to sit with the Wisconsin delegation to hear from members who appear;
C. The organizational structure of the AMA be published in the JOURNAL; and
D. The hearing be announced to the membership for whatever time is decided by the Council.

On motion of Doctor Foley, seconded and carried, these recommendations were approved with the suggestion that the hearing be held Monday night along with the reference committees of the House of Delegates.

11. Oath of Office

The oath of office was administered by the chairman to the new councilor from the twelfth district, P. G. LaBissoniere, MD.

12. Division on School Health Recommendation

In reference to medical examinations for students participating in athletics, the Division recommended that a yearly physical examination, acceptable to all organizations such as camps, state agencies, etc., be given; and that a standard report form be developed for reporting to any agency or organization requesting such information.

This recommendation was forwarded to the Council after the Division considered a suggestion of the WIAA that perhaps athletic examinations need not be given on a yearly basis. The Division requested concurrence of the Council that such examinations should be done each year and should suffice for any sport entered into.

On motion of Doctors Edwards–Rohde, carried, the Council approved the recommendation of the Division with regard to athletic examinations and a standard report form.

13. Report of Planning Committee

Doctor Manz reported on the committee's initial review of the Constitution and Bylaws and indicated recommendations would be prepared for submission to the House of Delegates in reference to:

A. Modernizing the "purpose" clause in the Constitution;
B. Election of councilors;
C. Terms and duties of standing committees;
D. Bringing all provisions on membership classes and dues into one chapter;
E. Including resident, honorary and special service members as "fully paid" members.

The Council accepted this as a progress report and will expect to hear further from the planning committee in May.

14. Report of Executive Committee

Doctor Nordby reported the following recommendations:

A. Publication of Council Minutes

On motion of Doctors Lewis–Edwards, carried, the Council approved the recommendation that official minutes to be published in the Journal for future reference, and that a summary of important actions be reported promptly to the membership either in the GREEN SHEET or by special mailing.

B. Wisconsin Health Care Review, Inc; Committee on Peer Review

On motion of Doctors Egan–Rohde, carried, the Council adopted a statement of duties of a Council Committee on Peer Review, formerly the Advisory Committee on Utilization Review Programs of the Commission on Medical Care Plans, as follows:

The Committee on Peer Review shall:

1. Initiate, explore, and bring to the attention of the Council suggested policies and programs relating to peer review in Wisconsin;

2. Serve as the advisory and coordinating body within the Society for the development of medical peer and utilization review on a statewide basis, including the establishment of local and/or district peer review committees;

3. Serve as the initial appellate body for peer and utilization review in the state to consider cases appealed from local committees involving the quality and utilization of medical care; and

4. Function as the medical component for implementation of peer review under Wisconsin Health Care Review, Inc.

Members shall be appointed by the Council for terms of three years, staggered, with a maximum of three consecutive terms.

C. Perinatal Health Care Authority

The Council had requested the Executive Committee to consider an acceptable alternative to a hospital bed tax on obstetrical patients to fund this program if created through legislation.

On motion of Doctors Edwards–Foley, carried, the Council approved the recommendation of the Executive Committee that the Society applaud the objectives of the Wisconsin Association for Perinatal Care, but suggest that general tax funds be substituted for bed tax support of certain aspects of the program.

D. Citizen Physician of the Year

On motion of Doctors Foley–Huth, carried, the Council approved the recommendation that the Planning Committee be asked to develop criteria for an annual Society award to a physician for civic activity.

E. Surgical Care–Blue Shield

On Sunday morning Doctor Nordby reported an action of the Executive Committee overlooked in his Saturday report to the effect that he be authorized, as chairman of the Council, to initiate correspondence with the Medical Society of Milwaukee County as to its official attitude toward the current financial status of Surgical Care; such action to be taken in light of the responsibility of the State Medical Society under section 148.03 of the statutes and its authority to charter county medical societies.

15. Election of Secretary

On motion of Doctor Smejkal, seconded and carried, Earl R. Thayer was reelected Secretary and General Manager of the State Medical Society.

16. Report on Menominee County

Mr. Thayer reported that National Health Service Corps personnel for Menominee County would not be available until after July 1 and indicated that efforts would be continued to find interested physicians to go there on a volunteer basis until the government fulfills its promise.

17. Waukesha County Medical Society Communication to Councilors and Others

Doctor Nordby said he had written the county society president, acknowledging the communication and offering encouragement to its members for their interest in annual meeting and other Society affairs. It was inferred that several resolutions may be forthcoming from this county society for consideration by the House of Delegates.

18. Association of Health "Professionals" Created in Northern Wisconsin

The Council received a report for information on a newly created association "with the primary aim of providing continuing education programs for health professionals and the general public." Officers and directors include a chiropractor, podiatrist, and public health nurse among others.

The Council recessed at 5:30 PM until 9:30 AM Sunday, February 27.

19. CES Foundation

Mr. Thayer announced plans for the first meeting of the Foundation under its new structure wherein the Council and nonmedical trustees constitute the board of trustees. This will be during the annual meeting after the last session of the House of Delegates, and the corporate members representing county medical societies will be invited to attend.

He also advised the Council that the Wisconsin Rural Rehabilitation Corporation will again be a major source of support for the freshman medical student externship program in 1972.

20. AB 475—Collective Bargaining for State Employees Including Physicians

The Council had received information during the week on this bill which very recently was amended to include state-employed physicians, dentists, nurses and others in the health field in collective bargaining units. There had been indications that the physicians might be interested in having the Society act as its bargaining representative, although the Teamsters Union and the State Association of Career Employees (SACE) had already indicated an interest in representing the "professionals."

The question presented the Council was whether it was desirable for the Society to so act, assuming that it was legally possible, and further, that the Wisconsin Employment Relations Commission would accept the Society as a bargaining agency.

It was suggested by the chairman that the Wisconsin Association of Professions might be the appropriate organization to serve in this capacity. After considerable discussion the following actions were taken by the Council:

A. On motion of Doctors McRoberts–Egan, carried, the Council directed further investigation of the possibility of the State Medical Society acting as a bargaining agency.

B. On motion of Doctors Rohde–McRoberts, carried, the Council stated its interest in so acting, but if unable to do so, that it will attempt to help the membership through the Wisconsin Association of Professions, it being understood that SACE is available for this purpose in any event.

21. Report of Finance Committee

Doctor Dettmann reported the following special considerations and recommendations by the Finance Committee in its review of 1971 experience and development of the 1972 operating budget:

A. A total review of legislative activity will be undertaken in 1972.

B. The salaries of several employees were reallocated as between the Society and WPS budgets.

C. Contributions will be accepted via the Foundation from former commercial exhibitors toward expenses of annual meeting speakers.

D. Consideration will be given to securing bids for printing of the JOURNAL after the present contract expires.

E. With reference to PACE, the committee voted against renewal of the 1971 contribution of $10,000 from dues income for educational purposes of the organization.

The committee also recommended to the Council that the $20,000 note receivable from PACE, which has been carried as a reserve item, be written off.

On motion of Doctors Dettmann–Schmidt, carried, this recommendation was approved by the Council.

F. Budget for Legal Counsel

Doctor Dettmann indicated the committee would report further, probably in May, as to the projected expense for legal counsel after the professional liability study has been completed.

G. Employee Vacation Pay Accrual

On motion of Doctors Dettmann–Smejkal, carried, the Council approved setting up a vacation pay accrual liability for all Society employees as recommended by the CPA consultants.

H. United States Chamber of Commerce

While this organization has requested a substantial increase in dues from member associations, the committee proposed that the Society continue its membership at $100 annually.

I. Mileage Reimbursement

The committee reported approval of an increase in reimbursement for operation of privately owned automobiles for business purposes from 9¢ to 11¢ per mile.

J. Employees Pension Plan

As members of the Managing Committee of the Employees Pension Plan, the committee set the interest rate payable on employee contributions at 6% for 1972.

Doctor Dettmann then reviewed the proposed 1972 general fund operating budget as presented to the Council, taking into account the above actions and recommendations. He also commented on the favorable experience of WPS in 1971, with actual administrative expenses of 8.7% as against a budgeted 9.1%.

On motion of Doctors Egan–Rohde, carried, the report of the Finance Committee was accepted by the Council.

Mr. Thayer discussed the necessity for action at the local level to continue the educational and other purposes of PACE. He also announced the resignation of Doctor Kief as chairman of the board of directors of PACE and the Council asked that the Secretary send him an expression of thanks for his efforts.

22. Adjournment

The Council adjourned at 10:30 AM to meet as members of the SMS Realty Corporation.

EARL R. THAYER
Secretary

Approved: May 7, 1972
E. J. NORDBY, MD
Chairman

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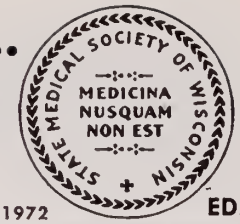

OPHTHALMOLOGY

MAY 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DIVISION ON VISION

The Division on Vision of the Commission on State Departments of the State Medical Society of Wisconsin met April 20 in Madison. Ophthalmologists who attended were: MDs George E. Nadeau, chairman, Green Bay; James V. Bolger, Waukesha; John B. Hitz, Milwaukee; Elmer E. Johnson, Madison; Glen E. McCormick, Wauwatosa; and James C. Allen, Madison. Also attending were Gertrude E. Howe, MD of the State Department of Health and Social Services and H. B. Maroney, assistant secretary of the State Medical Society.

The Division members agreed that a standard eye examination form should be developed to replace a variety of forms now being used in various State departments.

Several changes in the driver's license form were recommended including the deleting of the stereopsis report on the form. The consensus was that 20/40 (O.U. open) was adequate distance acuity for an unrestricted license. The question of the amount of peripheral vision required was not resolved. It was pointed out that in only 3 percent of automobile accidents does decreased visual acuity appear to be a factor. This 3 percent is small compared to the high percentage of accidents associated with the consumption of alcohol.

There was considerable discussion of the education of the public, especially teachers, about dyslexia. It was felt that ophthalmologists have not talked to enough teacher groups about this problem. It was pointed out that the dyslexia program last January by the Milwaukee Ophthalmological Society was of great success in educating the teachers and school psychologists. It was noted that the State Department of Health and Social Services and local community teacher organizations are eager for information on this subject. Since ophthalmologists have not shown any interest in talking to these educators, the educators have turned to optometrists for information about dyslexia, the Division members acknowledged. In cooperation with the Section on Ophthalmology, the State Department of Public Instruction, and the Wisconsin Education Association, the Division on Vision plans to assist in implementing a Conference on Learning Disabilities to be held at the time of the Wisconsin Education Association meeting next fall.

The proposed optometry school at the University of Wisconsin–La Crosse is being studied by a number of committees consisting of ophthalmologists, optometrists, University people, outside consultants, and non-medical people. The committees are operating through the University of Wisconsin and the Wisconsin Regional Medical Program in attempting to establish the need for optometrists in the state. Elmer E. Johnson, MD and Matthew D. Davis, MD of Madison are members of these committees.

James V. Bolger, MD, Waukesha, brought up the possibility of a mobile eye unit staffed by residents and other ophthalmologists to be used in the delivery of health care to the more remotely populated areas of Wisconsin. Anyone with further ideas in this proposal should communicate directly with him.

NEW OPHTHALMOLOGIST IN ASHLAND

John Doty, MD has joined MDs Robert J. Sneed and Kenneth A. Morrow in the practice of Ophthalmology in Ashland. Doctor Doty completed his ophthalmology residency at the University of Wisconsin in 1969. He was associated with the Dean Clinic in Madison before moving to Ashland.

OPHTHALMOLOGIST IN FORT ATKINSON

Leslie H. Salov, MD has opened an office to practice ophthalmology in Fort Atkinson. He was born in Newark, N.J., 56 years ago. He received his BS degree from Upsala College, East Orange, N.J., and his MD degree at the University of Bun, Switzerland. He served his internship at Morristown (N.J.) Memorial Hospital and ophthalmology residency at Montefiore Hospital, Pittsburgh, Pa.

During 1963 he was awarded a study grant from the Bernard Baruch Medical Foundation to visit and study at eye clinics in Europe in connection with his research in diabetic retinopathy.

DR. HOLMSTROM JOINS SHEBOYGAN CLINIC

Robert D. Holmstrom on May 1 joined The Sheboygan Clinic's medical staff in the department of ophthalmology. He had been in solo practice in Sheboygan for the past year. A native of Miami, Fla., Doctor Holmstrom served on the staff at Great Lakes Naval Hospital for two years prior to coming to Sheboygan. He was certified by the American Board of Ophthalmology in October 1971 and is licensed to practice medicine in Georgia, Florida, California, and Wisconsin. He is a 1962 graduate of Emory University Medical School, Atlanta, Ga., and served as a U.S. Navy flight surgeon from 1963 to 1971, completing three years resident training in ophthalmology at the San Diego Naval Hospital from 1967–1970. □

NEWS HIGHLIGHTS

Beaver Dam Hospitals Form New Corporation

Officials of Beaver Dam's two hospitals, St. Joseph and Lutheran, signed an agreement recently consolidating the two institutions into a single community health care corporation, Beaver Dam Community Hospitals, Inc. The new corporation became effective April 1.

The hospitals are now one new non-denominational unit with both hospitals losing their religious identity and ownership. Under the new ownership the former St. Joseph Hospital now serves as the acute care hospital while the former Lutheran Hospital serves as the extended and chronic care hospital. The changeover is expected to be made gradually over a six-month period.

The consolidation was termed "inevitable" by Lutheran Hospital Association president Robert W. Dott. He said, "duplication of facilities is unnecessary and costly, and not in the best interest of the community we serve."

Sister Francis Borgia Rothlubber, president of St. Joseph Hospital Board, stated, "We earnestly believe that we are participating in an effective plan to provide for the best future in health care service for the Beaver Dam community."

Alan A. Ehrhardt, MD,* secretary of the Dodge County Medical Society, said, "We are now in a much better position to attract medical specialists to our area, and to provide the community with modern medical care economically and without duplication."

Gerald S. Sjobeck, former Lutheran Hospital administrator, has been appointed administrator for the two hospitals. J. Douglas Richie, former St. Joseph Hospital administrator, has assumed an administrative post at St. Clare Hospital, Monroe. Both men have been credited with playing a major role in the development of the consolidation.

The acute care hospital (St. Joseph) has a total of 112 beds and employs a staff of 200. The extended and chronic care hospital (Lutheran) employs 270 persons and has 135 beds of which 35 are nursing home beds.

The Beaver Dam Hospitals serve an area of over 65,000 people. There are 35 physicians in the medical community and approximately one-third are board certified specialists.

Plans for consolidation began in 1967 and final approval by both groups was reached in February 1972. A designee board became the governing board of the new corporation effective April 1.

Crossroads Health Center

. . . recently became a reality with the signing of a lease agreement between the executive committee of the Marquette Rural Health Center and MDs R. E. Baylon* and G. A. Mejia.* The building, to be completed by August 1, will include in its 6,400 square feet a mental health department, x-ray department, modern laboratory, emergency facilities, general medical clinic, central administration area, and on-site dispensing pharmacy. Groundbreaking ceremonies were to take place this month. The Center will be dedicated as a living memorial for veterans of Adams and Marquette counties who have served in war and peace. It is being built at the Highway 23–51–82 intersection in Marquette County. The doctors have the option to buy the building at the end of their lease agreement.

PHYSICIAN BRIEFS

Martin J. Smith, MD*

. . . chairman of the Department of Internal Medicine and director of the special hematology laboratory at the Gundersen Clinic, Ltd., La Crosse, recently presented a paper at the American College of Physicians Annual Meeting held in Atlantic City, N. J. The paper was entitled "The Impaired Responsiveness of Chronic Lymphatic Leukemia Lymphocytes to Allogeneic Lymphocytes."

Dr. Smith

Dr. Clemons

John E. Clemons, MD*

. . . La Crosse, recently presented a paper at the eighth annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc., in Palm Beach, Fla. Doctor Clemons' paper was entitled "Replacement of a Totally Amputated Auricle." He is chairman of the Department of Otolaryngology, Maxillofacial and Plastic Surgery, Gundersen Clinic, Ltd.

Michael Barton, MD

. . . formerly of Douglas, Wyo., recently became associated with the Boscobel Clinic. Doctor Barton received his medical training at Geneva and Basle, Switzerland, graduating in 1948. He came to the United States and took postgraduate training in surgery in New York. He was certified by the American Board of Surgery in 1959. He previously had practiced in Oconto before moving to Douglas, Wyo.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Leandro M. Queniahan, MD
. . . Baraboo, recently established a medical practice in Baraboo. A 1961 graduate of the University of Santo Tomas, Manila, The Philippines, Doctor Queniahan was located in Whitewater and Wild Rose prior to coming to Baraboo. His general practice residency was taken at Ravenswood Medical Center, Chicago, and general surgery residencies at the American and St. Joseph hospitals, Chicago.

Jacob Lemann, Jr., MD*
. . . Wauwatosa, recently was elected president of the medical staff of Milwaukee County General Hospital. Other MDs elected were; David V. Foley,* Wauwatosa, vice-president; and John R. Litzow,* Elm Grove, secretary.

Elizabeth R. Baldwin, MD
. . . La Belle, Fla., former Marshfield Clinic physician, is the migrant health director in La Belle, Fla. The late Dr. Robert S. Baldwin, her husband, held this position before he died in 1967. She was the first woman doctor appointed to the Wisconsin State Board of Health.

Lan A. Nelson, MD
. . . Duluth, Minn., will become associated with M. W. Asplund, MD* at the Bloomer Clinic in July. Doctor Nelson graduated from the University of Wisconsin Medical School and is completing his internship at St. Luke's Hospital, Duluth.

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Medical College's Pathology Building Dedicated

The Medical College of Wisconsin (MCW) held a two-day scientific program, May 4 and 5, to mark the dedication of its new Pathology Building.

Four nationally known pathologists shared the speaker's podium with 18 members of the MCW pathology faculty. The meetings took place in Milwaukee County General Hospital's Coffey Auditorium, which is adjacent to the new building.

In addition, six local and guest speakers participated in the dedication ceremonies May 5.

At the scientific meetings guest speakers were Robert A. Good, MD, PhD, professor and head of the Department of Pathology at the University of Minnesota School of Medicine; Robert J. Lukes, MD, professor of pathology at the University of Southern California School of Medicine and chief hematological pathologist at the Los Angeles County–University of Southern California Medical Center; Michael N. Berry, MD, DPhil, research associate at the Bruce Lyon Memorial Research Laboratory and clinical chemist at Children's Hospital Medical Center, Oakland, Calif.; and Arthur C. Allen, MD, clinical professor of pathology at the State University of New York, Downstate Medical Center, Brooklyn.

The American Society of Clinical Pathologists has proclaimed 1971–1972 to be "The Year of Pathology" and this scientific meeting has been named an official proceeding.

At the dedication ceremonies Milwaukee County Executive John Doyne and William Dolan, MD, president of the American Society of Clinical Pathologists, were guest speakers. Four speakers represented the Medical College: Robert S. Stevenson, chairman of the Board of Directors; Gerald A. Kerrigan, MD,* dean and vice-president; Edward J. Lennon, MD,* associate dean; and Jon V. Straumfjord, MD, PhD,* professor and chairman of pathology.

A reception and tours of the facilities followed the dedication.

The new Pathology Building is attached to the east side of Milwaukee County General Hospital (MCGH), and thus makes possible the consolidation of the MCW and MCGH Department of Pathology in a single location. MCGH has been the Medical College's principal hospital affiliate for more than 40 years. MCW has 28 full-time pathologists, 21 of whom have joint appointments with MCGH and have offices in the new building.

Owned and operated by MCW, the new structure houses the academic functions of the Department of Pathology. The research laboratories and teaching rooms, as well as the faculty offices, are here, while the pathology service laboratories are located in the hospital proper.

The L-shaped, two-storied structure cost approximately $800,000. It is the first structure for an MCW basic science department to be located on the Milwaukee County health complex campus.

Following the recommendations of a 1967 Governor's task force, the Medical College is preparing to expand its incoming freshman class to at least 167 students. Because larger facilities will be necessary, MCW is discussing with the hospital and the County Board of Welfare the possibility of constructing a basic science medical education building on the campus.

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H. David Friedberg, MD

. . . former chief of Cardiovascular Section, VA Center, Wood, has opened an office for the exclusive practice of Cardiology in Milwaukee. Doctor Friedberg has just returned from a lecture tour of England. He gave the inaugural lecture of the Electrocardiographic Society of London entitled, "The A–V Node is a One-Way Street," at Guys in London. He also lectured on the results of coronary surgery at the Royal Postgraduate Medical School, London.

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Carl Andrew, MD*

. . . Platteville physician for 48 years, recently was awarded the ABCD Award by the Platteville Kiwanis Club for his long, "above and beyond the call of duty" service to the community. Doctor Andrew graduated from the Marquette University School of Medicine in 1915. He came to Platteville after serving in the Medical Corps during World War I; and finding the community without a hospital, he established one.

Rostislav Ivsin, MD

. . . Saukville, recently opened an office in Saukville. The community had been without a physician for 50 years. Doctor Ivsin graduated from Charles University in Prague in 1957. He served his internship at Columbia Hospital, Chicago, and has been on the staff of the Blanchard Clinic, Cedarburg. Doctor Ivsin also is on the medical staff of St. Alphonsus Hospital, Port Washington, and St. Joseph's Community Hospital, West Bend.

James D. Whiffen, MD

. . . has been appointed acting chairman of the Department of Surgery, University of Wisconsin Medical School, Madison, to fill a vacancy created when Anthony R. Curreri, MD,* was named assistant vice chancellor of the UW Center for Health Sciences. Doctor Whiffen will serve as chairman while a nine-member search and screen committee chaired by Richard, Hong, MD, associate dean of the Medical School, seeks a permanent chairman. Other members of the committee include S. C. Alexander, MD,* Department of Anesthesiology; Norman O. Becker, MD,* Fond du Lac surgeon; Stanley Goldfarb, MD, Pathology; John H. Greist, MD, Psychiatry; Ward A. Olsen, MD, Medicine and a staff member of the VA Hospital; Richard E. Rieselbach, MD, Medicine; Gloria Sarto, MD,* Gynecology and Obstetrics; and Charles E. Yale, MD,* Surgery.

Dr. Falk Returns from Third Trip to Vietnam

Victor S. Falk, MD* of Edgerton, recently returned from his third trip to Vietnam as a Volunteer Physician, an AMA program. In the Mekong Delta where he was located, he reports many fewer civilian war casualties than he experienced in 1966 and 1967. Also, the Vietnamese surgeons in that part of the country last year did 97% of the operations whereas three years before the Americans had done approximately two-thirds. All of the United States military medical teams which in the past had been assigned to the care of Vietnamese civilians have been withdrawn.

The medical school at Saigon is now graduating 200 physicians each year. With the child mortality rate decreasing and the life expectancy increasing, the population of South Vietnam has increased by 50% in recent years.

After leaving Vietnam, Doctor and Mrs. Falk toured through the South Pacific Islands of New Caledonia, the New Hebrides and Guadalcanal, where he had been stationed thirty years before.

American College of Physicians

Five Wisconsin specialists in internal medicine were granted fellowships in the American College of Physicians in April. They are: MDs Nicholas L. Owen,* Brookfield; James W. Jefferson, La Crosse; Irvin M. Becker* and Walter J. Hogan, Milwaukee; and Jordan N. Fink,* Wood. They have earned this distinction through certification by their specialty boards, presentation of published material, evidence of scientific accomplishments and academic or hospital affiliations.

Anesthesia and Respiratory Disease Seminar

A seminar on Anesthesia and Respiratory Disease was conducted April 15 on the University of Wisconsin–La Crosse Campus. Physicians, nurse anesthestists, and inhalation therapists from Wisconsin, Minnesota, Iowa, and Illinois attended the one-day session which was sponsored by the Adolf Gundersen Medical Foundation.

Program chairman was John G. Jaeger, MD.* Moderators were Jose A. Campo, MD and David E. Goodnough, MD.* All are members of the Department of Anesthesiology, Gundersen Clinic–Lutheran Hospital.

Program participants were: Dean Crocker, MD, director of Respiratory Therapy, Children's Hospital Medical Center, Boston, Mass.; William Douglas, MD, Department of Internal Medicine, Mayo Clinic, Rochester, Minn.; E. P. Didier, MD, director of Respiratory Case Unit, Rochester Methodist Hospital, Rochester, Minn.; William S. Sykes, MD, associate professor of Anesthesiology, F. Eliska Atkins, MD, assistant professor of Anesthesiology, and Claude Taylor, MD,* professor of Anesthesiology, all three of the University of Wisconsin; and Sharon Tourville, RN, staff development coordinator, Intensive Care Unit, La Crosse Lutheran Hospital. Other speakers were Larry A. Lindesmith, MD,* A. C. V. Elston, MD;* Seuk B. Kang, MD,* of the Gundersen Clinic.

Milwaukee Gynecological Society

William W. Baird, MD* of Wauwatosa was installed as president of the Milwaukee Gynecological Society at its annual meeting April 10, succeeding Samuel G. Perlson, MD* of Shorewood. William A. Kretzschmar, MD* of Whitefish Bay was elected president-elect, to take office in 1973. David V. Foley, MD* of Wauwatosa was elected to a two-year term as secretary-treasurer. The Society is composed of 121 board certified and board eligible obstetricians and gynecologists in Wisconsin.

J. O. Chamberlain, MD*

. . . Milwaukee, chief of staff of Columbia Hospital, recently announced the election of the following MDs as chairman of their departments: Richard D. Fritz,* medicine; W. J. Boulanger,* surgery; and G. F. Burgess,* obstetrics–gynecology.

Frank P. Goldstein, MD*

. . . has recently become a diplomate of the Pan American Medical Association in the Section on Neurological Surgery. Doctor Goldstein is an assistant professor in the Department of Neurosurgery, Medical College of Wisconsin, Milwaukee.

John W. Cornell, MD*

. . . Cudahy, recently was named secretary–treasurer of the medical staff at Trinity Memorial Hospital, Cudahy, at its annual meeting. Charles E. Theisen, MD,* South Milwaukee, is chief of staff and named president-elect was Jacques Hussussian, MD*, Milwaukee.

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Robert Feulner, MD*

. . . has been named as the Waukesha County representative on the Comprehensive Health Planning Agency. The appointment was made by Alfred E. Kritter, MD,* president of the Waukesha County Medical Society.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1972

3 State Pharmacy Board Exams
3 Dane County Medical Society Insurance Advisory Committee
4 State Pharmacy Board Exams
4 Madison General Surgical Staff
4 Madison Urological Society
4 Madison Anesthesiology Society
5 Faculty and Junior Students, UW Medical School
6 Wisconsin Joint Practice Commission
6 Madison and Area Otolaryngologists Seminar
8 Executive Committee of SMS Council
10 Budget Committee, Woman's Auxiliary to the State Medical Society
11 National Board Exams, Senior Students of UW Medical School
12 National Board Exams, Senior Students of UW Medical School
13 Preceptors and Faculty, UW Medical School
14 Advisory Committee, Wisconsin Regional Medical Program
15 Wisconsin Association for Mental Health
15 Special Committee on the Shortage of Physicians
17 Dane County Medical Society Utilization Review Plan
18 Board Exams for Trained Practical Nurses
19 Ad Hoc Committee on Chiropractic
19 State Medical Examining Board
20 State Medical Examining Board
20 SMS Division on Vision
22 Wisconsin Society of Cytology
24 University of Wisconsin Hospitals Board
25 Educational Program on Diabetes for Health Professionals
29 SMS Commission on Health and Natural Resources

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

PHYSICIAN BRIEFS/NEWS HIGHLIGHTS *continued*

North Central Wisconsin Orthopedic Society

The Spring Meeting of the North Central Wisconsin Orthopedic Society was held April 21 with the following members attending: MDs W. I. Norton,* T. O. Miller,* R. L. Buechel,* and D. H. Kranendonk* of Wausau; C. A. Klasinski,* Stevens Point; W. O. Dietsche,* Wisconsin Rapids; and R. W. Mason* and H. Chen,* Marshfield.

Doctor Miller was reelected president. The Fall Meeting will be held in Marshfield with Doctor Mason as the guest host.

Planned Parenthood Regional Annual Meeting

Dedication of the Planned Parenthood Association of Wisconsin's Reproductive Health Center in Milwaukee was held April 10 in conjunction with the annual meeting of the Great Lakes Regional Council of Planned Parenthood–World Population April 9–12.

The Planned Parenthood Association of Wisconsin moved into its new quarters in March at which time an informal tour of the new facility was conducted. Mrs. Harold L. Miller, executive director, and members of the Board of Directors were available for interviews. One physician is a member of the Board: John D. Silbar, MD,* Milwaukee. Roland S. Cron, MD* is medical advisory chairman of the Association and Jay A. Larkey, MD,* is the medical director.

Physicians who participated in the four-day annual meeting program on comprehensive family planning were: Alan F. Guttmacher, MD, president, Planned Parenthood–World Population (PP–WP), New York, N.Y.; Carl J. Levinson, MD,* chairman, Department of Obstetrics–Gynecology, Mt. Sinai Medical Center, Milwaukee; Frederick J. Hofmeister, MD,* associate clinical professor, Department of Obstetrics–Gynecology, Medical College of Wisconsin, Milwaukee; Alfred L. Kennan, MD,* Midwest Medical Center, Madison; Frank N. Beckles, MD, associate deputy administrator for Health Services, National Center for Family Planning Services, Bethesda, Md.; George J. Langmyhr, MD, director of Medical Department, PP–WP, New York, N.Y.; Charles F. Whitten, MD, director of Clinical Research Center, Children's Hospital, Wayne State University School of Medicine, Detroit, Mich.; Edward R. Krumbiegel, MD,* commissioner of Health, City of Milwaukee; and Charles F. Dungar, MD,* diplomate of American Board of Ob–Gyn, Appleton.

University of Wisconsin–Madison Campus

A new building on the University of Wisconsin–Madison campus was named recently by UW regents in honor of a recently deceased faculty member, Harry A. Waisman, MD, who was a renowned leader in the fight against mental retardation.

The $7.1 million Harry A. Waisman Mental Development Center at Marsh Lane and University Bay Drive will be part of the planned Center for Health Sciences on the west end of the campus. It will include treatment, research, and training facilities as well as a school for mentally retarded children operated by the Madison Public School System. Its research facilities will include a one million-volt microscope, one of seven in the world and the first on a university campus.

A native of Milwaukee, Doctor Waisman was both a physician and biochemist who held four UW degrees. He died in March 1971 at the age of 58. Doctor Waisman's areas of specialty were hereditary diseases and chemical causes of mental retardation. He developed the PKU test to detect potential for mental retardation in newborn babies and enabled its prevention in some cases.

Dr. David Carlson Cited for Leadership

David J. Carlson, MD* of Wauwatosa has received Marquette University's Alumni Service Award for outstanding leadership and service to the University. He received the award April 22 at an Alumni Awards dinner held at the Ozaukee Country Club in Mequon.

Dr. Carlson

Since 1965 Doctor Carlson has been director of laboratories at St. Mary's Hospital in Milwaukee. He also has been a pathologist at Oconomowoc's Memorial Hospital and Lakeland Hospital in Elkhorn.

Doctor Carlson has been a clinical professor of pathology at the Medical College of Wisconsin since 1950, and also he is a volunteer lecturer and instructor in Marquette's physical therapy and medical technology programs.

He has held a variety of positions in the American Cancer Society from 1963 to the present, and also is a member of the Wisconsin Society of Pathologists and the Catholic Physicians Guild. He is now serving as president of The Medical Society of Milwaukee County, and he is an alternate delegate of the State Medical Society of Wisconsin to the American Medical Association.

Doctor Carlson is a past president of the University's alumni association; former member of the athletic board; former chairman of the medical gifts division of the Greater Milwaukee Program; and a former Class Agent for the Annual Marquette Fund. He is now chairman of the geographic program for the Fund.

Doctor Carlson received his BS degree from Marquette in 1939, his MD degree in 1943, and a master's degree in Pathology in 1951.

Milwaukee Society Endorses SE Wisconsin Sickle Cell Center

The Board of Directors of the Medical Society of Milwaukee County has announced its endorsement of the Southeastern Wisconsin Sickle Cell Center for its activities in sickle cell screening.

The Sickle Cell Center at Deaconess Hospital is among the largest metropolitan projects in the country utilizing a mass research testing and follow-up system to identify and test for the sickle cell trait, the Society stated.

David J. Carlson, MD,* president of the Medical Society, in a letter to George Lane, MD,* medical director of the Center, said that, "we are especially impressed with the excellence in scientific and administrative competence of those individuals responsible for directing your program."

Doctor Carlson indicated that two physician committees of the Medical Society had made a study of the program prior to the Board of Directors' unanimous decision to endorse the Southeastern Wisconsin Sickle Cell Center.

"The Medical Society is aware of other sickle cell screening programs being developed in our community. We have not yet been provided with the data on these other programs which would merit our official endorsement at this time," Doctor Carlson said.

The initial objective of the Southeastern Wisconsin Sickle Cell Center is to screen the approximately 100,000 black population of the greater Milwaukee area for the hereditary blood disease. At all community screening locations, volunteer nurses and medical technicians are under the personal supervision of a physician.

Jacques Hussussian, MD*

. . . Milwaukee, was named president-elect of the medical staff of Trinity Memorial Hospital. MDs Wayne L. McFadden* and John W. Cornell* were named vice-president and secretary-treasurer, respectively.

Harold P. Rusch, MD

. . . professor of oncology and director of McArdle Laboratories, University of Wisconsin Center for Health Sciences, on March 8 was appointed by President Nixon to a two-year term on the National Cancer Advisory Board. The board advises and assists National Cancer Institute Director Dr. Carl G. Baker in carrying out research and other activities of the Cancer Act of 1971. The 18-member board will be joined by the present membership of the National Advisory Cancer Council which the new board supersedes. □

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OBITUARIES

Ernest S. Olson, MD, 70, Racine, died Jan. 10, 1972, in Racine.

Born on Mar. 24, 1901, in Lemont, Ill., Doctor Olson graduated from Rush Medical College, Chicago, in 1930 and served his internship at Los Angeles County General Hospital. During World War II, he served in the U. S. Medical Corps as a lieutenant colonel.

Doctor Olson was pathologist-in-charge of clinical laboratory at VA hospitals in Aspinwall, Pa., Dayton, Ohio, and the Bronx, N.Y., before becoming director of clinical laboratory services and chief pathologist at St. Luke's Hospital in Racine in 1949. In 1969, Doctor Olson resigned his position but remained on the laboratory staff at St. Luke's as pathologist emeritus until his death. He also was on the staffs of Burlington Memorial and Highridge hospitals.

He held memberships in the College of American Pathologists, American Society of Clinical Pathologists, Wisconsin Society of Pathologists, American Association of Blood Banks, Wisconsin Association of Blood Banks, and International Society of Blood Banks. He also was a past president of the Wisconsin Association of Blood Banks and editor of the WABB Bulletin.

Doctor Olson also belonged to the Racine County Medical Society, State Medical Society of Wisconsin, and American Medical Association. His many medical publications are listed under his name in "Who Is Who" in Wisconsin (Moore's) (1960). He has written a number of papers since, some pending publication at the time of his death.

Eight days after his death, Doctor Olson was posthumously awarded an honorary membership in the Milwaukee Academy of Medicine.

Surviving are his widow, Lillian; two daughters, Mrs. G. Edward (Marilyn) Birchfield, Evanston, Ill., and Mrs. Roy (Lillian) Mackal, Chicago, Ill.; and two sons, Ernest, Jr., Switzerland, and Dr. Charles Olson, Modesto, Calif.

Elizabeth Comstock, MD, 96, Arcadia, died Jan. 15, 1972, in Neillsville.

Born on Sept. 2, 1875, in Arcadia, she graduated from the University of Wisconsin with a Bachelor of Science degree in 1897, attended Johns Hopkins Medical College, Baltimore, Md., for one year and received her degree in medicine from the Philadelphia Women's Medical College in 1901. Doctor Comstock interned in Philadelphia and then served at the New York Infirmary for Women and Children for several years on a volunteer basis. In 1907 she was placed in charge of the Infirmary, a position she held until returning to Arcadia in 1923. The oldest practicing woman physician in Wisconsin, Doctor Comstock retired in 1966 after 65 years of professional service as a physician and surgeon.

Doctor Comstock was a member of the committee which initiated formation of the Woman's Auxiliary to the State Medical Society of Wisconsin and in 1954 was a delegate to the Congress of International Medical Women's Association in Italy. In 1961, she received the Council Award of the State Medical Society of Wisconsin.

She was a member of the International Association of Medical Women, American Medical Women's Association, United States Committee, Inc. of the World Medical Association, a member of Trempealeau–Jackson–Buffalo County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Doctor Comstock never married but is survived by Mrs. Earl (Frances) McCandless, Wausau, whom she raised from childhood. □

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CAUTION: Federal law prohibits dispensing without prescription.

Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.

Drug Dependence: Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.

Usage In Pregnancy: The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.

Usage In Children: Not recommended for use in children under 12 years of age.

Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.

Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.

Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF APRIL 17, 1972

NEW MEMBERS

Almazar, Deo, Wittenberg Clinic, Wittenberg 54499
Awen, Charles F., 1328 Spence St., Green Bay 54304
Birkemeyer, Eugene J., P. O. Box 8, Rhinelander 54501
Boury, Harb N., 25A University Houses, Madison 53705
Bresnick, George H., 1300 University Ave., Madison 53706
Cadmus, Robert R., 10625 West North Ave., Milwaukee 53205
Carson, John P., 630 S. Central Ave., Marshfield 54449
Darvin, Teodoro A., 146 E. Water St., Shullsburg 53586
Dicus, William T., 2040 W. Wisconsin Ave., Milwaukee 53233
Edgett, Joseph W., Jr., 1836 South Ave., La Crosse 54601
Garay, Fema So, 100 W. Monroe St., Port Washington 53074
Gerling, Gerard M., 1836 South Ave., La Crosse 54601
Giraldo, Abel, 2388 North Lake Dr., Milwaukee 53211
Groessl, Peter J., 1711 Shawano Ave., Green Bay 54303
Handel, Stanley F., 8700 West Wisconsin Ave., Milwaukee 53266
Harding, Harold W., 506 E. Longview Dr., Appleton 54911
Holmes, Richard A., 8700 W. Wisconsin Ave., Milwaukee 53226
Horwitz, David A., 1300 University Ave., Madison 53706
Hunold, Edward A., 2500 Hall Ave., Marinette 54143
Kim, Soo Yun, 3001 South 56th St., Milwaukee 53219
Kovac, Albert P., 2400 W. Villard Ave., Milwaukee 53209
Kuter, David P., 2818 Kingston Dr., Madison 53713
Lloren, Jose T., Jr., 80 Sheboygan St., Fond du Lac 54935
Madden, Peter N., 2405 Merlin Way, Brookfield 53005
Maniquiz, Reynaldo C., 600 Bay St., Chippewa Falls 54729
Mayersak, Jerome S., P. O. Box 927, Wisconsin Rapids 54494
Obcena, Ricardo S., Route #2, Cadott 54727
Oge, Vedad, 424 Broad St., Lake Geneva 53147
Parker, John P., 630 S. Central Ave., Marshfield 54449
Powell, Joseph E., 441 E. Seventh, New Richmond 54017
Ramos, Teodoro M., 315 Mt. Zion St., Ripon 54971
Reigel, Donald H., 8700 W. Wisconsin Ave., Milwaukee 53226
Schmidt, Mary H., 114 Columbus St., Sun Prairie 53590
Sen, Sisir K., 611 St. Josephs Ave., Marshfield 54449
Stevens, Michael L., 630 S. Central Ave., Marshfield 54449
Tarver, Milton G., 2411 W. Capitol Dr., Milwaukee 53206
Victoria, B. M., Jr., 948 North 12th St., Milwaukee 53233
Wagner, Stephen F., 630 S. Central Ave., Marshfield 54449
Webster, Stephen B., 1836 South Ave., La Crosse 54601
Willis, Robert T., 1011 N. 8th St., Sheboygan 53081
Wright, Warren K., 912 Pearl St., Chippewa Falls 54729

CHANGE OF ADDRESS

Bogle, Warren C., 2525 North Mayfair Rd., Wauwatosa 53226
Boone, Max L. M., University of Arizona, School of Medicine, Tucson, Ariz. 85702
Brazy, Robert R., 2525 North Mayfair Rd., Wauwatosa 53226
Buck, Charles R., 2806 E. McCloskey Pl., Aberdeen Proving Grounds, Md. 21005
Buckley, Clarence H., R.R. #6, Menomonie 54751
Buscaglia, Christopher J., 5310 S. Magellan Dr., New Berlin 53151
Clarke, B. Earl, 3010 Foothill Rd., Santa Barbara, Calif. 93105
Curran, William P., 1111 Langlade Rd., Antigo 54409
deGuzman, Eleuterio A., 2525 North Mayfair Rd., Wauwatosa 53226
Denio, Martin J., Jr., 2525 North Mayfair Rd., Wauwatosa 53226
Dhaliwal, Kulwant S., 6336 Sheridan Rd., Kenosha 53140
Dibble, James B., Route #4, Box 222, Eau Claire 54701
Dorman, Thomas W., 2908 Taylor Ave., Racine 53403
Driessel, Richard H., 2352 Snead Court, Titusville, Fla. 32780
Edelblute, Lyle H., P. O. Box 1054, Green Bay 54305
Fisher, Raymond S., 608 Church St., Allenton 53002
Fosdal, Frederick A., 2727 Marshall Ct., Madison 53705
Geimer, Nicholas F., 8430 W. Capitol Dr., Milwaukee 53222
Goldstein, Frank P., 524 Main St., Racine 53403
Gonlag, Harry, 733 West Clairemont Ave., Eau Claire 54701
Griffith, Donald R., 733 West Clairemont Ave., Eau Claire 54701
Hartwick, John P., 5016 West Washington Blvd., Milwaukee 53208
Henke, Samuel L., 733 West Clairemont Ave., Eau Claire 54701
Hoelscher, Kenneth K., 2816 West Ville du Parc Dr., Mequon 53092
Holmes, John F., 533 Vernal Ave., Milton Junction 53564
Hunkel, Victor H., 9009 W. Clarke St., Milwaukee 53226
Jekel, Jerome M., 1601 East Olive St., Milwaukee 53211
Kennedy, Richard L., 733 West Clairemont Ave., Eau Claire 54701
Kim, Dai Kap, 450 Dena Circle, Racine 53402
Landsberg, Manfred, 2015 North Lake Dr., Milwaukee 53202
Larson, Arthur N., 3628 Karwin Dr., Dayton, Ohio 45406
Luy, Enrique W., Wild Rose 54984
Manning, Timothy A., 1920 West Hart Rd., Beloit 53511
Marcich, Zivko P., 4716 S. Packard Ave., Cudahy 53110
Martinez, Marcial E., 2410 Winding Way, Vandosta, Ga. 31601
Mateicka, William E., 2525 North Mayfair Rd., Wauwatosa 53226
Mathwig, Robert J., 121 West 8th Ave., Stanley 54768
McCabe, Lloyd B., US Army Hospital, USMA, West Point, N. Y. 10096
Miller, Wallace C., 523 Main St., Racine 53403
Morrow, Kenneth A., R.R. #1, Box 61A, Ashland 54806
Niebauer, Walter E., 174 North Avon Ave., Phillips 54555
Owen, George E., 733 W. Clairemont Ave., Eau Claire 54701
Paulson, Walter O., 733 W. Clairemont Ave., Eau Claire 54701
Prentice, John W., 1951 Northeast 39th St., Apt. 137, Light House Point, Fla. 33064
Quanbeck, David T., 123 Hospital Dr., Watertown 53094
Queniahan, Leondro, 708 Elizabeth St., Baraboo 53913
Quitzon, Andres F., 2245 West Brantwood Ave., Milwaukee 53209
Rhomberg, Bernard B., 2525 North Mayfair Rd., Wauwatosa 53226
Rodenbeck, Alfred F., 5900 South 92nd St., Milwaukee 53228
Schmidt, Carl W., Box Elder Rd., Marshall 53559
Schulte, George C., 3618—8th Ave., Kenosha 53140
Sholtes, Clause A., 801 Chestnut St., Apt. 1709, Clearwater, Fla. 33516
Smith, Victor W., N84 W15493 Menomonee Ave., Menomonee Falls 53051
Torstenson, Ordean L., 1313 Fish Hatchery Rd., Madison 53715
Vogel, Thorn L., 2508 East Racine St., Janesville 53545
Waters, Darwin D., 1008 Farwell Ct., Madison 53704
Wiley, Albert L., Jr., 6723 Bertner St., Houston, Tex. 77025

DEATHS

Glisch, William P., Milwaukee County, Feb. 10, 1972
Nightingale, Michael F. P., nonmember, Feb. 13, 1972
Willison, Donald M., Eau Claire–Dunn–Pepin County, Feb. 13, 1972
Towne, William H., Outagamie County, Feb. 23, 1972
Johnson, Frances, Milwaukee County, Mar. 9, 1972
Benkendorf, Charles, Brown County, Mar. 11, 1972
Hargarten, Lawrence W., Milwaukee County, Mar. 17, 1972
Hildebrand, George B., Winnebago, Mar. 23, 1972
Nester, Hansford D., Eau Claire–Dunn–Pepin County, Apr. 1, 1972
Sincock, Henry A., Douglas County, Apr. 9, 1972 □

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

June 3: Annual scientific session—*Coronary Heart Disease: 1972, Practical Clinical Approach for Physicians and Nurses,* Wisconsin Heart Association, at Madison General Hospital, Madison.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

July 15: Congress of Delegates Meeting, Wisconsin Academy of Family Physicians, at Midway Motor Inn, Wausau.

Aug. 28–Sept. 1: Emergency Care Course, American Academy of Orthopaedic Surgeons, at Madison. Course chairman: Kenneth M. Sachtjen, MD, 2715 Marshall Court, Madison, Wis. 53705.

Sept. 6–8: Tenth Annual Cancer Chemotherapy Conference, University of Wisconsin, Madison. Info: Dr. G. Ramirez, 714-C University Hospitals, Madison, Wis. 53706.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Internal Medicine, joint meeting with American College of Physicians, Holiday Inn, La Crosse.

Sept. 15–17: Annual Meeting, Wisconsin Radiological Society, Pioneer Inn, Oshkosh.

Sept. 23: Cancer Conference, Marshfield Clinic Foundation for Medical Research and Wisconsin Division of American Cancer Society, Marshfield.

Sept. 23–24: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

1972 NEIGHBORING STATES

July 21–22: Annual Session, North Central Region, American Association of Medical Clinics, Holiday Inn, Urbana, Ill. INFO: John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

Aug. 7–10: American Health Congress '72, Chicago–McCormick Place, Chicago, Ill. Info: Call Mrs. Ruth Blaine, 312/645–8220.

Oct. 14–20: Annual Otolaryngologic Assembly of 1972, Eye and Ear Infirmary of University of Illinois Hospital, Chicago, Ill. Info: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 13–18: Course in Laryngology and Bronchoesophagology, Department of Otolaryngology of Abraham Lincoln School of Medicine and University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill. Info: Dept of Oto., U of Ill. Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 24–25: Conference on Radiology in Otolaryngology and Ophthalmology, Chicago, Ill. Info: Galdino E. Valvassori, MD, Radiology Dept., Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680.

1972 AMA

June 18–22: Woman's Auxiliary 50th Anniversary, Convention, St. Francis Hotel, San Francisco, Calif.

June 18–22: AMA Annual Meeting, St. Francis Hotel, San Francisco, Calif.

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Oct. 2–6: Annual Clinical Congress, American College of Surgeons, Fairmont Hotel, San Francisco, Calif.

1973 NEIGHBORING STATES

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1973 OTHERS

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

* * *

Recent Progress in Hematology. Presented by University of Wisconsin, June 8–10. Topics of current importance in hematological diagnosis and management. Specifically disorders of coagulation, hemoglobinopathies, management of malignancies of the hemopoetic system, and status of blood transfusion. Conference structured to allow maximal participation by registrants in small groups with nationally known experts in the field. Guest faculty: Ernest Beutler, MD, City of Hope Medical Center; Frank H. Gardner, MD, Presbyterian–University of Pennsylvania Medical Center; Donald Pinkel, MD, St. Jude's Children's Research Hospital; Helen M. Ranney, MD, State University of New York at Buffalo; and Oscar D. Ratnoff, MD, Case Western Reserve University. Info: Miss Patricia Morton, Program Coordinator, Department of Postgraduate Medicine, 610 North Walnut Street, Madison, WI 53706.

continued on next page

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin
Madison
1972

ON-CAMPUS CONFERENCES

June 2–3: *The North Central Dialysis and Transplant Conference*

June 8–10: *Recent Progress in Hematology*

July 22–23: *Ski Patrol Conference*

Aug. 28–Sept. 1: *Emergency Care Conference*

Oct. 20–21: *Podiatry Seminar*

Further information may be obtained from
COORDINATOR OF POSTGRADUATE MEDICAL EDUCATION
The Wisconsin Center
702 Langdon Street
Madison, Wisconsin 53706

Tenth Annual Cancer Chemotherapy Conference has been scheduled September 6–8 at the University of Wisconsin, Madison. The conference will consist of a review and forward look of anticancer therapy, multiple drug therapy of solid tumors and leukemias, role of x-ray therapy, immunology, and virology in the treatment of cancer. Further information may be obtained from Dr. G. Ramirez, 714-C University Hospitals, Madison, Wis. 53706.

Coronary Sessions for Physicians and Nurses will be presented at the Wisconsin Heart Association's 1972 Annual Scientific Session, from 9 AM to 4:40 PM, June 3, at Madison General Hospital in Madison. Sessions are open to all physicians and nurses in Wisconsin.

The Annual Session is aimed at reducing death and disability from heart disease by improving the early detection and treatment of coronary-prone individuals. It will include detailed information on diagnostic techniques and medical treatments.

Scheduled topics include the electrocardiogram, exercise testing, the role of emotion and anxiety in heart disease, laboratory aids and cardiovascular drugs. Moderators for the event are Dean A. Emanuel, MD, Wisconsin Heart president, and John H. Morledge, MD, Wisconsin Heart president-elect. Thirteen cardiovascular specialists will be featured speakers.

Wisconsin Heart's annual meeting will follow the scientific session at 6:30 PM at the Hoffman House West, Madison.

American Academy of Orthopaedic Surgeons will sponsor a training course on emergency care and transportation of the sick and injured in Madison, August 28–September 1, at the Wisconsin Center.

Invited to attend the four-and-a-half day course of lectures and practice demonstrations are ambulance attendants, nurses, firemen, police officers, and others who work with persons requiring emergency attention.

The comprehensive training meeting will be held in cooperation with the University of Wisconsin Center for Health Sciences, and directing the course is Kenneth M. Sachtjen, MD, Madison orthopaedic surgeon.

Faculty members of the University of Wisconsin Center for Health Sciences and others will lead work practice sessions on the best ways of evaluating, treating, removing, and transporting the public in a wide variety of emergency medical situations.

Other groups cooperating in presenting the course are the Madison Police and Fire departments, Wisconsin State Patrol, American Red Cross, and the Dane County Traffic Department.

For information and registration forms, those interested may write to Mrs. Ann Johnston, Coordinator, Emergency Care Conference, Room 558, 610 Walnut Street, Madison, Wis. 53706.

Annual Otolaryngologic Assembly of 1972 will be held October 14–20 in the Eye and Ear Infirmary of the University of Illinois Hospital. The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, MD. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology. Interested otolaryngologists should direct their inquiries to the mailing address: OTOLARYNGOLOGY, P. O. Box 6998, Chicago, Ill. 60680.

A separate, but correlated course, **Conference on Radiology in Otolaryngology and Ophthalmology,** will be held this year on Friday and Saturday, November 24 and 25, under the guidance of Galdino E. Valvassori, MD. For further information about the radiology conference, write to Professor Valvassori, Radiology Department, Abraham Lincoln School of Medicine, P. O. Box 6998, Chicago, Ill. 60680.

Course in Laryngology and Bronchoesophagology. The Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, will conduct a continuing education course in Laryngology and Bronchoesophagology November 13–18. The course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, MD. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. Interested physicians will please write directly to the Department of Otolaryngology, University of Illinois at the Medical Center, Postoffice Box 6998, Chicago, Ill. 60680.

Cancer of the Digestive Tract. Postgraduate course sponsored by American Gastroenterological Association, July 20–22 at Aspen Institute for Humanistic Studies, Aspen, Colo. Designed for practicing physicians. Approval has been requested for 12 hours credit by American Academy of Family Physicians. Registration fee: $80 for AGA mem-

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CONTRIBUTIONS—CES FOUNDATION

March 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for March 1972:

Nonrestricted

Woman's Auxiliary to the State Medical Society	Contribution
State Medical Society Members	Voluntary contributions of 381 MDs
State Medical Society	Memorials: E. S. Olson, MD, Elizabeth Comstock, MD, H. B. Keland, MD, T. A. Judge, MD, S. J. Leibenson, MD, F. W. Pope, MD, G. J. Swartz, MD
Dr. & Mrs. Joseph M. Lubitz	Memorial: Mrs. Dorothy Enzer
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Dr. & Mrs. Walter Smejkal	Memorial: Mr. Gordon Lund
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David N. Goldstein, MD	Memorial: Charles Benkendorf, MD
Katherine J. Galos, MD	Memorial: Ernest Olson, MD

Charitable Disabled Physicians

State Medical Society Members	Voluntary contributions of 32 MDs
George R. Andrews, MD	Contribution

Scientific Teaching

State Medical Society Members	Voluntary contributions of 10 MDs

Tormey Memorial Medallion Fund

State Medical Society Member	Voluntary contribution of 1 MD
Dr. & Mrs. T. W. Tormey, Jr. & Family	Memorial: Mrs. Mary Frusher

Cyrus G. Reznichek, MD Student Loan Fund

Robert Heinen, MD, Mrs. John T. Wright	Memorial: C. G. Reznichek, MD

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CONTRIBUTIONS—CES FOUNDATION *continued*

Student Loan Fund

State Medical Society Members ---- Voluntary contributions of 53 MDs

George W. Hilliard, Jr., MD Fellowship Fund

State Medical Society Member ----- Voluntary contribution of 1 MD

Brown County Loan Fund

State Medical Society Members ---- Voluntary contributions of 2 MDs
George Nadeau, MD ---------- Contribution
Woman's Auxiliary to the Brown County Medical Society -------- Contribution

W. D. Stovall, MD Memorial Account

State Medical Society Member ----- Voluntary contribution of 1 MD
John G. Beck, MD, John J. Beck, MD, Robert Heinen, MD, Robert E. Urbanek, MD, Vernon County Medical Society ---------- Memorial: W. D. Stovall, MD

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Dr. Grinde Bell Account

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Barbara Scott Maroney Memorial Fund for Research on Diabetes

H. B. Maroney, II ---------- Memorial: Mrs. Roy Marston

Medical Student Summer Externship Program

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William B. Hildebrand, MD ------- Contribution

Danforth Memorial Student Loan Fund

Mrs. Quincy Danforth ---------- Contribution

Other Than CESF Projects

State Medical Society Members ---- Voluntary contributions of 41 MDs

Memorial

State Medical Society Member ----- Voluntary contribution of 1 MD □

MEETINGS *continued*

bers; $100 for non-members; $25 for those in training status. Info: Mrs. Frances T. Chalmers, AGA Postgraduate Course, Box 190, McLean, Va. 22101 (tel. 703/356–2693).

National Conference on Human Values & Cancer, sponsored by the American Cancer Society, at Regency Hyatt House, Atlanta, Ga., June 22–24, 1972. This Conference will be concerned with understanding the problems of the cancer patient from inception of disease to cure or failure. Also, the effects on the family and professionals who are directly concerned. Emphasis will be placed on the humanistic problems of the patient including interpersonal relationships, rehabilitation, employability, insurability, the right to know, the spiritual needs, and the hopes for miracles. Members of the medical and related professions, and other individuals concerned with the cancer patient are invited to attend. No registration fee. Preregistration is requested. INFO: William M. Markel, MD, National Conference on Human Values & Cancer, American Cancer Society, Inc., 219 East 42nd Street, New York, NY 10017.

American Association of Medical Clinics, North Central Region, will hold its annual session July 21 and 22 at the Holiday Inn, Urbana, Ill. The meeting will be hosted by the Carle Clinic Association, Urbana, and will commence with an afternoon registration period, Friday, July 21.

The two-day session will include panel discussions on: (1) computers in medicine, (2) physicians' assistants, and (3) clinics and medical education.

All interested physicians, clinic administrators, and observers are invited to attend. Additional information may be obtained by contacting John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901. □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

Emergency Services. The Hospital Emergency Department in an Emergency Care System.
American Hospital Association, 840 North Lake Shore Dr., Chicago, Ill. 60611. 1972. 98 pages. Price: $2.50.

The Care of Minor Hand Injuries. By Adrian E. Flatt. The C. V. Mosby Co., St. Louis, Mo. 1972. 293 pages. Price: $21.50.

The Chinese Art of Healing. By Stephan Palos. Bantam Books, 666 Fifth Ave., New York, N. Y. 10019. 1972. 237 pages. Price: $1.50.

Neurohypophysial Hormones (Ciba Foundation Study Group). Edited by G. E. W. Wolstenholme and Joan Birch. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 146 pages.

Lactogenic Hormones. (Ciba Foundation Symposium). Edited by G. E. W. Wolstenholme and Julie Knight. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 416 pages.

Personality and Science (Ciba Foundation Blueprint). Edited by I. T. Ramsey and Ruth Porter. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 158 pages.

Professional Uses of Adhesive Tape. By Johnson & Johnson. Johnson & Johnson Company, New Brunswick, N. J. 08903. 1972. 124 pages.

Mental Health Program Reports—5. National Institute of Mental Health. Department of Health, Education, and Welfare, 5600 Fishers Lane, Rockville, Md. 20852. 1971. 388 pages. Price: $1.75.

Crime and Justice: American Style. By Clarence Schrag, PhD. National Institute of Mental Health Center for Studies of Crime and Delinquency, 5600 Fishers Lane, Rockville, Md. 20852. 1971. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 266 pages. Price: $1.00.

Textbook for Laboratory Assistants. By Irwin A. Oppenheim. The C. V. Mosby Co., St. Louis, Mo. 1972. 149 pages. Price: $4.90.

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BOOK REVIEWS

Bleeding Problems in Clinical Medicine

By Armand J. Quick, MD, Marquette School of Medicine. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 19105. 1970. 225 pages. Price: $9.50.

This recent book by Doctor Quick provides a thoughtful analysis of a complex subject, the size of which makes it available to the busy practitioner. He utilizes the case method and personal experience extensively, which not only adds interest, but also affords the reader an insight into the approach and thinking of a world renowned investigator. The strong points of the book are its historical approach and the considerable amount of first hand observations on bleeding problems which will keep their value long after theories have changed. Bleeding problems are presented in the three categories of vasopathies, thrombopathies and coagulopathies.

Doctor Quick quite naturally emphasizes the use of techniques pioneered in his own laboratory. He discusses hereditary bleeding diseases mainly, although, of course, the section on vitamin K deficiencies is authoritative. He also emphasizes diagnosis more strongly than therapeutic aspects which is, of course, where most of our information lies.

Although some of the theories in this book, such as the reasons for the prolongation of bleeding time by aspirin and the role of vasopathy in the Minot–von Willebrand syndrome, may not be universally accepted, they are thought-provoking and original.

In summary, Doctor Quick's vigorous and very personal approach to bleeding problems has produced a very readable and fact-filled book.—EDWARD B. CROWELL, JR., MD

Behavioral Sciences and Mental Health: An Anthology of Program Reports

National Institute of Mental Health, Chevy Chase, Md. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 1970. 419 pages. Price: $2.00.

This paperback volume is one of the most fascinating books I've ever had the opportunity to review. As the subtitle indicates, it is truly an anthology of program reports. The average government document is one of the most unreadable, boring, sterile accounts of scientific progress than can be imagined and this book, for $2.00, offers some of the most fascinating reading that can be obtained anywhere in the field of hard science, experimental science and theoretical science. In actuality, the volume reads very much like science fiction with readability and excitement factor that propels the reader through long and complex experiments. One is led through the complexities of picking up small clues and cues to the amazing serendipity of the investigators as well as some of the chance discoveries which have come to the attention of the experimenters only by long and tedious measurements.

The summaries and conclusions help to present in condensed form what many busy doctors would find themselves unable to do in the brief moments they have occasion to read some of the basic science material so essential to the upkeep of their fine mental mechanisms. The only discouraging part of the whole volume is the first chapter on the NIMH role in the behavioral sciences which unfortunately is coldly factual and philosophical in the tone of most governmental documents. It is, however, very informative and enriching to review how the Government has encouraged investigators to pursue items which at first view look utterly meaningless and almost ridiculous to pursue.

The book is divided into five sections and covers 25 separate program reports, some of which go back in their origins to as long as 25 and 30 years ago. Reports such as "Changing The Behavior of Animals" by Richard L. Solomon and "The Origins of Aggressive Behavior" by Sherwood L. Washburn excite interest because they appear to offer possible explanations for modern young people's problems of today as well as the treatment of some of our recalcitrant psychological and behavioral problems. Although these reports are carried only up to and including 1970, they are not behind the times at all and much of the information of this book has yet to come to general public knowledge.

Other fascinating articles are "Biological Bases of Memory" by James McGaugh and "The Physiological Imprint of Learning," by several investigators, makes one think twice before relegating any more cases to the group of the hopeless and untreatable. "The Role of Biological Clocks in Mental and Physical Health" by Kurt Richter which started over 30 years ago is most current in its impact on travel and the psychological pressures of changes in time and place to which man is subjected so violently today.

Without naming all the other exceptionally high quality program reports it is necessary to mention only that everything from sleep patterns, the effects of LSD, Coordination studies, hormone influences, computer studies, and the effects of social class on mental illness are covered in this volume. Even for those who have little or no laboratory interests or application to their work or experimental curiosity, this volume provides an opportunity for Osler's advice to be fulfilled with ease, that is—to leave at your bedside a medical book which you can read on awakening or before you go to sleep to help leave imprints which are of importance and of assistance in evoking awareness of the changing picture of medicine every day. This fact is so apparent after you start reading this volume that it is very difficult to put it down even when the chapters run long. In some respects there are qualities of writing in this volume which are akin to the Sunday supplement type of feature coverage so that more than the medical profession could certainly be interested in the material presented. It was hard to turn this volume back to the library after reviewing it.—B. H. GLOVER, MD □

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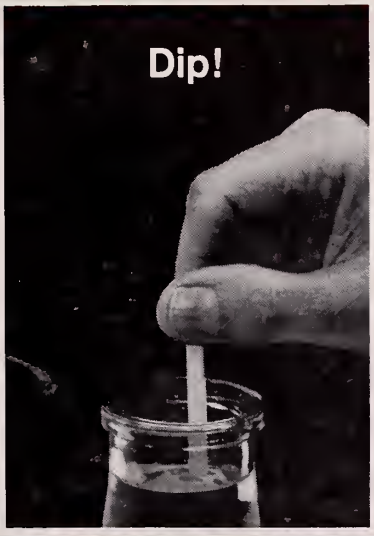

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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

PRESIDENT'S MESSAGE TO THE HOUSE OF DELEGATES

ROBERT F. PURTELL, MD
Milwaukee, Wisconsin

NOW IF YOU GENTLEMEN will give me just a few minutes, I am going to reminisce for a bit before I tell you some of the things I have in mind. Sometimes I feel like an old Civil War veteran when I start doing this, but I would like to remind those of you who do not know—and I don't think there are many here who will recall—my first appearance before the House of Delegates of the State Medical Society of Wisconsin. It was in 1941, in Madison. I was not a delegate. I appealed to the House to give me an opportunity to speak to the House, and I was extended the privilege. This had to do with Blue Cross.

A year later Dr. Dexter Witte and I appealed to the Council of the State Medical Society; I was then not a councilor, nor have I ever been. We were granted an opportunity to present our thoughts to the Council. That was in January 1942, at the University Club.

In the corridor were two men whom we walked by as we went in. One was a skinny, sandy-haired redhead and the other was a dark-haired man whom I didn't know. I later found out that the skinny redhead was Charlie Crownhart, and his partner was Robert Murphy. George Crownhart was the secretary at that meeting, and that was kind of a fearsome experience for me because, first of all, I thought everybody sitting around the table was pretty ancient and forbidding. I will not go into the details of either of those meetings except to let you know that early in my career I was interested in the State Medical Society and its operations. Both of those appearances related to the Blue Cross Plan.

I then served for twenty years on the Blue Cross Plan as a director, and later had the privilege of serving for seven years on the Surgical Care Plan. And now, believe it or not, I have completed the circle and I am serving on the WPS Board of Directors.

But the best is yet to come. I secured figures today of just what these three Blue operations have done for the people of the State of Wisconsin. In the 32 years that Blue Cross has been in operation (and these are all as of January 1, 1972), Blue Cross has paid $960,979,324, paying back to the subscriber 92 percent of the premium dollar, and operating on a 6.5 percent operational percentile. The 1972 estimate is somewhere in the neighborhood of $150 million.

Surgical Care began in 1943, and as of January 1, 1972, has paid out to subscribers a total of $284,175,098 and estimates to do about $63 million this year, 1972.

Wisconsin Physicians Service began its operation in 1946 and to date, January 1, 1972, has paid out $274,577,871 as benefits to its subscribers, and its estimate for this year is about $52 million.

Totaling the three Blue Plan operations in the last 32, 28, and 25 years, a total of $1,519,752,239—all done on a voluntary basis. I cannot conceal the pride I have that I had a little bit to do with that immense figure. It is something to think about when politicians start talking to us about doing it better.

I would like to reminisce for a little bit about this past year as president-elect. I have traveled throughout the State of Wisconsin and I have met with hundreds of my brother physician members of the State Medical Society. I have visited with them and exchanged ideas with them, argued with them a little bit, and in general it has been a wonderful experience.

I have had a close-up, intimate view of the State Medical Society in operation. I have watched the committees and commissions and Council and the WPS operating committee. I have observed the personnel in their day-to-day operations, and I cannot praise the whole operation enough. It is a startling experience to see men from all over the State of Wisconsin go to Madison, sit through an entire afternoon, then drive home, giving of their time and experience to the day-to-day operation of the multitude of committees and commissions that make up the State Medical Society.

I believe the State Medical Society is extremely fortunate in having Mr. Earl Thayer as our secretary, and to the other top echelon men, Tom Doran, Ray Koenig, Bernie Maroney, David Reynolds, Howard Brower, John LaBissoniere, Jack Brown, and all the others, I have nothing but the highest of praise. They have shown a devotion and fidelity that beggars the imagination. Most of all,

Presented before the House of Delegates of the State Medical Society of Wisconsin at the 131st Annual Meeting, May 8, 1972, Milwaukee.

the strength of our Society lies in the 4,500 members who make up our State Medical Society. We have only 600 who are not members in the State of Wisconsin, and of those 600 about 350 are residents and interns.

During the past year I have watched our president, George Behnke, do a splendid job as the leader of the State Medical Society, and I believe organized medicine in this State owes George a very deep debt of gratitude for the vigor and the talent that he has displayed as our president. Congratulations, George!

We are living in troubled times, and it affects not only medicine but the entire country. The ten-year frustrating and unpopular war in Vietnam; our domestic problems of unemployment, poverty, racial troubles, drugs, crime, over-population, abortion, have sort of stunned us all and have left grave marks on the face of this country. But there is a lot that is good about this country.

We have hundreds of millions of good, law-abiding citizens—we have them here in our State—who never make the headlines. We have a whole generation of youth coming up, for whom drugs and crime and vandalism and all the rest are no problem. The health of our nation is good. We have controlled infectious diseases. We have brought maternal and infant mortality down almost to an irreducible minimum. And yet why do the politicians zero in on the practice of medicine and our voluntary health system?

The so-called heath care crisis—we had a symposium on this last week. This is a shining example of the liberal press as it attempts to create a climate of distrust. I think there are problems within the nation's health services. I also think there are problems within the nation's boilermakers and brewery workers. So this health crisis thing, to me, is a little bit of a charade.

On May 12, 1971, the day after our annual meeting adjourned, Governor Lucey issued his Executive Order No. 19, creating the Governor's Health Planning and Policy Task Force, which he directed to develop a comprehensive health plan and policy which would serve as a model for the nation. I don't know whether many of you have picked up that one phrase in his Executive Order—the Wisconsin Health Planning and Policy Task Force is to develop a model for the nation.

The Governor appointed approximately 43 citizens of the State, both providers and consumers of health. Earl Thayer is on this Task Force; Dr. Ben Lawton is on it; the Dean of the Medical College and the Acting Dean of the UW Medical School are on it, as are many others.

Part of the Order was that a final report by this Task Force would be due the Governor by October 1, 1972. As Doctor Behnke cited, the chairman of this Task Force, Mr. Carley, displayed recklessness, I might call it, in announcing that the Task Force was going to introduce legislation putting the health care of this State under government control, licensing, quality control, price control—and it has not as yet reached the Task Force for a vote. I think he has pretty well negated any value that he might have had as Chairman of this Task Force.

The medical and hospital services of this State, I believe, are at a high level of quality. It would be ridiculous to believe that there is no room for improvement. Indeed, if there ever comes a time when there is no room for improvement, we will then have reached a stalemate in medicine. We have never conceded that there is no room for improvement in any of our endeavors.

One of the first chores that was given to me as president- elect was to sit with the Governor and plead with him not to sign the Workmen's Compensation Act and the commercial carrier automobile insurance law which was going to drum in the cult of chiropractic as a legal fact. We did not impress him very much. The day after our visit with him, purely for political reasons (and it could not have been for rational reasons) he signed these two bills into law. I concur with our President on the development of the special ad hoc Committee on Chiropractic. I think we have given enough time on this subject in committee and Council meetings not to dwell on it any more here today.

Organized medicine has been distracted and detracted from its primary work of attending to the ill and injured, by politicians who wish to take us under their control. Medicine and physicians collectively should continue to search for secrets that still lie beyond the horizon. In every way we should strive to be better doctors, to teach and to exchange medical information and knowledge among ourselves.

I would like to close by making a special plea to you, my brother physicians, that we always keep before us the plight of the poor. It is a calamity to be sick or injured; it is a double calamity to be sick, injured, and poverty-stricken. Christ Himself has assured us, in spite of Mr. Humphrey, that the poor we shall always have with us. After 40 years in the practice of medicine I am quite convinced that we will always have the poor in our care. I believe that for these people we should reserve our most tender care. □

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

That Old Black Magic

PHYSICIANS TODAY ARE FACED with a diffusion of their hard won scientific knowledge. This diffusion seems to be moving toward those in other disciplines, many of whom we consider to be less informed than we are, and some we consider to be not informed at all. But does this approach merit us any gain to merely busy ourselves with practice and rise above the growing competitive skill of those about us. Psychiatry tried this route, especially in the area of psychotherapy, and now stands in minority position with tightly organized psychology. Your editor being trained and licensed in both fields has seen this from the inside.

I cannot claim to be as clearly perceptive in relation, say to medicine and chiropractic, but over the years all of us have found patients frankly discussing their experiencies with the "lesser healers." It sounds all too familiar. Just last week, in my own practice, these two vignettes occurred. A man of 32, highly successful in his business world started by his father, had suffered back pain for several years. His attempts to find relief included at least three orthopedic surgeons. He shamefully admitted he went to a chiropractor, who "found" that one leg was half an inch shorter than the other and the use of a pad on the short leg relieved his pain. A woman of 40, professor in a university underwent extensive internal medical tests for radiating pain from upper back to left abdomen, including a gastrointestinal series. She finally went to an osteopath who "discovered" a spasm of several small muscles in her back and completely relieved her in three treatments. These stories will *not* impress a medical reader, but they do apparently impress people, even educated ones like in the anecdotes above, and the legislature in our state. Years ago, in Indiana, I recall attending a court trial of a chiropractor, brought up for failure to treat cancer. Long lines of grateful patients waited for hours for their chance to testify in his behalf. Now what is this all about? In defense of the chiropractic? No, of course not. But it is an alert to physicians to pay some heed to the *phenomenon* of the chiropractic, to pick some possible values from it, to understand it sufficiently to *effectively* counter it rather than pontificate against it. I do not know if it can be done but let me remark on several aspects of the "chiropractic-experience," which after all is a two way affair between persons.

It is not sufficient to say that those who are not willing to study the long years of medicine are merely seeking the same role in an easier way. The chiropractic represents conviction that a single cause–effect sequence exists, and that if the sequence is understood and manipulated (sorry, no pun intended) all will be well. Now this kind of solution to the ills that beset mankind is both charming and seductive. Any physician who has felt the sting of a patient's anger when more time and more tests are necessary will understand. That numbers of patients would turn to a simpler system seems human, if not scientific. Yet the doctor who tries to compete on this level, and becomes arbitrary and full of answers, soon finds himself busy as can be with persons who demand more and more of this sort of quick answers, and like the hypnotist, soon loses respect for himself, or at best, soon exhausts himself. Most physicians find no need to compete on this level. To disdain the patient's wishes, even though they be childlike, is to fail to meet the patient on his own terms. The other extreme, to sell the gold brick of oversimple answers, is the chiropractor's stock in trade.

Of course it is difficult to appear concerned for the well-being of patients without drawing the fire of those who already feel doctors make too much money, and are merely greedy for more, and hope to get more by "stealing" patients from the chiropractor. The ancient lambaste against the powerful person is easily served by crying "money" whenever the doctor points the finger of "fraud." A diatribe against false doctrines can often backfire, as described. Thus it might be well to ask how best to handle the position of power and even authority that still remains, for the time at least, with the MD degree. If our defense against quackery is no more successful than our defense against socialization of medicine, if indeed our primitive methods backfire and solidify opposition, then a frontal attack on lesser cults might even further weaken what is fast becoming an ancillary (if not secondary) position in the health field. One thing we could learn from the chiropractic is how to survive in the face of onerous and unreal public expectations. How the chiropractor does it is of interest to some physicians. Speculations include the sexual stimulation of skin contact; the more spiritual values of laying on of hands; pure chicanery based on fast talk, quick touch, and false hope; pseudo-scientific mumblings about "it seems to work and comfort;" or the opposite "it does nothing at all is just craziness." It is true that the laying on of hands has fallen from its ancient pedestal into disrepute. Internists are allowed to touch during a physical but seldom at bedside (although some wise ones do). Psychiatrists have gotten so far away from antique medicine that it is considered unethical to touch at all. Just what skin contact is or can do has never really been understood. It might not have to be used as in chiropractic to be of help.

The concept of hope is only beginning to be thought about in psychiatry, although many a physician has known its efficiency in hastening healing or sometimes in performing seeming miracles. Hope, however, can be a thing of the spirit, and not tied to slick tongues and gratuitous wishes, so that we might learn something about hope from the *existence* of the chiropractic though perhaps not from the chiropractor himself. We need not be so crass as to be dishonest, to use the strong element of hope for whatever value it can be. It could at least be studied, not dismissed just because misused by one group of men. Perhaps this essay will in some measure serve to stir interest in the general phenomenon which chiropractic brings to our attention.—RH

The Neglected Family

In their article, "Parents of Severely Ill Newborn Infants," Doctors Zachman and Graven have made a significant contribution to recent efforts to reestablish parents as human beings. In an age when it has seemed appropriate to ridicule, cajole, harangue, and indict parents for their ineptitude in raising children, it is refreshing to find sympathy directed toward the distressed parents.

Doctors Zachman and Graven have sensitively reviewed the significance of pregnancy to parents who are preparing for parenthood. The authors have touched on the tremendous panorama of emotion that attends the anticipation of a baby, be it the first or the sixth. There is humor and pathos, anger and fear, anxiety and hope, tears and wonderment as the nine months of gestation progress. It is a crucial time in a marriage, especially if this is the couple's first child and a meaningful time in the lives of all family members in subsequent pregnancies. The family anticipates with eagerness the day when the tiny infant is placed in their arms to be caressed and cuddled. When, however, the newborn infant is severely ill and is immediately wafted away to be placed in a sterile, monitored Isolette, this privilege is no longer allowed. The primary concern becomes the survival of the infant. To the parents who stand with noses pressed against the glass gazing at their "untouchable" child, we have proffered little attention or regard.

So we say congratulations to the authors who state, "The purposes of this report are to describe

ongoing programs designed with consideration for the unfortunate parents of sick newborn infants." This article not only addresses the needs, the fears and the wishes of the parents, but describes an already existing program for meeting the "family crisis." The program is in effect at St. Mary's Neonatal Intensive Care Unit in Madison, Wisconsin. Many methods have been developed of communicating to the family, both parents and siblings, the problems and progress of their infant. The use of tapes, newsletters, telephone and personal conferences all reflect the unique sensitivity to the needs of parents. For it is by meeting these needs of parents that we eventually meet the needs of the child. It is unfortunate that the usual monograph on hospital care of infants does not consider this.

Parenthood is a very important phase of human development. Erikson termed this development "generativity" because it concerns the establishment of the next generation. As with all developmental phases, this must be nurtured and rewarded by feedback gratification rendered through the infant. If the newborn is sick, these gratifications—the warm, cuddly body which snuggles against the parent's neck—the grasping by the tiny hand of the fingers of the siblings or father—the suckling from the mother's turgid breast—these are the missing reinforcements of parental feelings. To make up for these, the authors have sought many ways to communicate to the parents that their infant is touchable and alive and human in spite of the fact that it is under glass, being cared for by machines which beep and buzz and tend to give an unreal, inhuman atmosphere to the Intensive Care Unit. The tremendous effort to care for and nurture not only the infants but also the parents is commendable. This sensitivity toward the needs of the parents is, as the authors imply, also directed toward the survival and welfare of the infant when he returns to the home.

It is apparent that much thought and planning have gone into the establishment of this Madison program which both educates and provides emotional support and counsel to worried, anxious parents. We hope that the message of the article stimulates serious thought about the family crisis which arises upon the birth of a sick newborn infant. It is not only the infant who needs emergency care but also the parents and the siblings. Too often in the frenzy of caring for the "emergency child" we forget the "emergency parents." If, after being bypassed and ignored during the weeks of intensive care to their infant, the parents are resentful and "nonaccepting," should we be surprised and critical of them? Better we look at the birth of a sick newborn baby as, indeed, a family crisis and not be satisfied with merely caring for the newborn.—LUCILLE B. GLICKLICH, MD, Milwaukee □

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New Perspectives on Abortion Reform

We want better reasons for having children than not knowing how to prevent them. DORA RUSSELL

THE CASE FOR REPEAL of restrictive laws on abortion now seems stronger than ever. Twelve months experience with New York's new permissive abortion law indicates many benefits from abortion reform.[1, 2] New York City health department figures, since inception of the new law, indicate the following salutary trends:

1. A decline in maternal mortality in New York City to an all-time low of 2.9 maternal deaths per 10,000 live births. Prior to abortion reform the rate was 5.3 maternal deaths per 10,000 live births.
2. A decline in infant mortality to a new low (20.7 per 1,000 live births). This desideratum has occurred because abortion is now available to the very young, the unwed, and the woman with many previous pregnancies.
3. A decline in New York City's total birth rate.
4. The first decline in the number of illegitimate births in New York City—while increasing in many states without permissive abortion laws.
5. A dramatic *decrease* in the number of criminal abortions in New York City.
6. The increasing safety of legal abortions. The death rate in New York City has been 4.8 per 100,000 abortions, far less than the maternal death rate of 26 per 100,000. Mr. Gordon Chase stated that there is a trend toward obtaining abortions earlier during the unwanted pregnancy.[1] During the last 6 months of the study period the death rate has been only 3.7 per 100,000 abortions![2]
7. Nonwhite, Puerto Rican, and poor women received over half the abortions under the new law, many paid for by Medicaid. These women previously had little chance of obtaining safe legal abortions.

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Experience with permissive abortion laws in England, Hawaii, Washington, and Alaska has been comparable to experience in New York.

Abortion reform has not produced large numbers of depressed and guilt-ridden women.[3] In New York a study revealed 4.2% of legally aborted women were sad, and only 1.5% felt angry or negatively about their decision. The Osofskys reported that among Catholics, guilt and difficulty with the decision and the procedure have occurred somewhat more frequently than among non-Catholics, but even among this group "negative feelings have been minimal." In Sweden, women too healthy to receive an abortion developed more emotional incapacitation than those women who were disturbed enough to obtain an abortion. It is also worthwhile to observe that babies born to mothers who were denied a therapeutic abortion have a worsened developmental and social prognosis than do children in the population at large.[3]

Skilled and humane counseling may reduce psychiatric problems related to abortion to near zero. One of the principles of counseling women with unwanted pregnancies is to allow the women involved to *make their own decisions.* As doctors we may be factual experts or consultants, but we have no expertise in the area of *value judgments* except with regard to our own lives. Those who wish to "play God" have no business counseling women with unwanted pregnancies. It has been the experience of clergymen performing counseling for the Abortion Counseling Service of Minnesota that psychiatric complications following a legal abortion obtained in New York are minimal if the women involved made the decision freely.[4]

Opponents of abortion reform cling to the concept that abortion results in killing a "human being." For thousands of years philosophers have argued as to "when life begins." It would seem presumptuous to state that we now have the answer. We all recognize the *potential* of the embryo, but most of us believe that human life begins at birth. There are shades of gray in the argument, and many would grant that a fetus capable of sustained life, independent of the mother, deserves special consideration. The definition of abortion does not include the termination of an independently viable fetus,[5] and most doctors do not believe in the termination of pregnancies beyond the 24th week of gestation.

Now that safe legal abortions are a possibility, laws that abrogate a woman's right to safely terminate her pregnancy must be regarded as sexist. Historically, we are in the early stages of a fight by women for sexual self-realization and fulfillment. If women are to achieve the full potential of their sexuality, they must be allowed a free choice with

regard to unwanted pregnancies.[6] Opposed to this philosophy is the crumbling pseudo-morality of the Victorian–Puritan tradition. To paraphrase Henry Mencken, "The puritan is consumed with a gnawing concern that somewhere, somehow, someone is having a good time."

Finally, we ask the *wrong question* when we say, "Should women be allowed to have abortions?" Women have always obtained abortions. Even conscientious women, following contraceptive failures, have had to resort to *hazardous illegal abortions*. The question we now should ask is, "Shall women be allowed to obtain *safe legal* abortions?"

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Lipoprotein Phenotyping Now Available at the State Laboratory of Hygiene

The Clinical Chemistry Section of the State Laboratory of Hygiene recently announced the availability of lipoprotein phenotyping services to physicians and laboratories in Wisconsin. This chemical procedure is offered both for diagnosis, where the physician suspects a protein abnormality, and as a reference service to laboratories presently engaged in this test, for consultation/control purposes.—LABORATORY NEWSLETTER, The Wisconsin State Laboratory of Hygiene, February 1972 □

Blood Test to Detect Gonorrhea

A blood test to detect gonorrhea may be available within a year, according to VD specialists at the government's Center for Disease Control in Atlanta, Ga. At present, gonorrhea can be detected only by culturing the secretion from the genital organs. □

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SPECIAL

Occupational Safety and Health Act of 1970

GEORGE A. HELLMUTH, MD
Milwaukee, Wisconsin

From the Cardiac Work Classification Unit, Department of Physiology, Medical College of Wisconsin and Curative Workshop of Milwaukee.

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LEGISLATORS as well as society are disturbed about the unsolved problems and inequities of state administered workmen's compensation laws. Congress in endeavoring to meet its obligations of assuring safe and healthful working conditions for working men and women created a federal Occupational Safety and Health Act which includes a provision for a 15-member presidentially appointed National Commission on State Workmen's Compensation Laws. The Commission's purpose will be to "determine if such laws provide an adequate, prompt, and equitable system for injury or death arising out of or in the course of employment." A report of its findings will be made to the President and Congress by July 31, 1972.

The creation of this Commission indicates strongly that Congress wishes to make workmen's compensation laws more meaningful, and that some reform may be expected. Although it is difficult to state, hearings held thus far in Washington, Boston, and Chicago make it seem likely that the Commission may set up guidelines and standards for the states, directed toward a more equitable system rather than establishing total federalization of the system. The efforts of the President's Commission in this regard were most succinctly stated at the hearings where it was said that what was sought was "federal involvement based upon uniform federal standards" and that the Commission's goal should be to "tell the states what to do but not how to do it."

The state jurisdictions and their national organizations such as the Council of State Governments and the International Association of Industrial Accident Boards and Commissions (IAIABC) should support this endeavor through their research and through statistical studies which help to evaluate their role and progress in the state system, and through attempts at updating their administrations. These efforts should all be directed to determining whether the system is truly effective. The result should be constructive recommendations for the hearings and meaningful suggestions for planning and utilization of existing resources for the deliberations of the Commission. Thus, the Commission may assist the states in proposing uniform guidelines or a system of surveillance adaptable to each state. In this way, the hopefully improved state systems will be preserved and maintained to perform the function for which they were intended. If the states fail however to accept the challenge, federal governmental control may pose a threat to our present state workmen's compensation system.

The Commission as well as considering such problems as wage replacement benefits and greater coverage for all workers will also deal with the medical aspects of workmen's compensation. Steady liberalization of decisional law has largely impaired the original medical-legal intent of workmen's compensation laws. This is due in part to the current social milieu and the ineffective use of medical knowledge and the adversary system, particularly where there is conflicting medical testimony in the adjudication of disputed cases. For example, our studies in Wisconsin showed that over 50% of work-connected cardiac claims awarded were, according to American Heart Association criteria, medically unjustified. In few disputed cardiac claim cases was there scientific support to establish an alleged causal relationship between the onset of a heart attack and physical activity on the job. One of the sad results of such miscarriage is that 50% of all Wisconsin industry rejects the cardiac worker applying for a job.

The role of rehabilitation, which is now the most serious and neglected problem in the restoration of the worker under compensatory medicine, will also be studied and carefully scrutinized by the Commission, particularly in its substantive, legislative, and administrative provisions. The medical and allied health professions must play a major role in assisting and formulating medical aspects of comprehensive, multidiscipline, and optimal rehabilitation in the statutory provisions for total medical care of the injured worker regardless of the cost or duration.

The basic concepts of workmen's compensation, which is our first form of social insurance, are just, and the laws which have steadily been improved have benefited many hundreds of thousands of workers; and although workmen's compensation is not fully recognized as being such, it has been the most effective means of promoting safety in industry throughout the country in the past 60 years. In addition, it is economically one of the lowest of all industrial-employer benefit payroll costs (less than 1%), and even if current existing medical limitations were removed, the rate of increase of the total cost of workmen's compensation would be only 1% to 3%.

However, little progress has actually been made in adapting proposed updated medical recommendations within the state system in workmen's compensation where the crux of the problem now is a lack of medical surveillance, limited medical coverage, and a neglect of optimal medical and vocational rehabilitation. This is unfortunate since uniform guidelines for medical standards have been offered by the American Medical Association (AMA), the Council of State Governments, and the IAIABC as well as by the Department of Labor. These guidelines could be useful to the courts and the legal and medical professions. They could provide, among other factors, a more equitable means of presentation of correct scientific evidence before the hearing officer without the conflicts now frequently posed by the adversary system. These recommendations are adequate but what is lacking by and large is the conviction, instrumentation, and *implementation* in the state workmen's compensation system of these recommendations by workmen's compensation administrators, state legislators, concerned professions, and by labor and management. If the states fail to heed these and other recommendations, and if barriers inhibiting progress in forensic medicine and rehabilitation continue to exist, the President's Commission may very well impose uniform standards which the states will have to meet.

Although it is too early to prognosticate, there may be a consideration of a federal system of payment under Social Security, broader coverage by private health and disability insurance or the National Health Insurance Act which is now being studied by Congress. The advantage of one or more or a combination of these payment systems would be that they may improve a much needed occupational health care program. Perhaps these systems would also assist in reducing or eliminating much of the medical-legal dispute in court over the grey area of the compensability of non-traumatic, medically non-occupational, and natural disease "injuries" which were originally not as liberally applied under the law and which, in any event, should be reevaluated.

If the President's Commission recommends a synthesis of the medical restoration recommendations made by the AMA, the Council of State Governments, the IAIABC, and the Department of Labor on a state level, the medical profession must become more active in implementing these guidelines through organized medicine. The establishment of a medical director, medical advisory committee, and rehabilitation department—all under a coordinating director of workmen's compensation—will only be successful if the state and county medical societies offer their talents, knowledge, and recommendations to the workmen's compensation commissioners.

Although Wisconsin has one of the best records in the workmen's compensation system with 4% disputed claims, there are still medical areas in need of improvement such as inadequate medical surveillance (medical representation on the advisory committee on workmen's compensation, a medical director, and advisory medical committee in the Department of Industry, Labor and Human Relations); greater usage of independent non-partisan expert medical witnesses, pre-trial conferences and the second injury fund; and better liaison in rehabilitation with the state Division of Vocational Rehabilitation.

The medical problem however has broader implications than this brief essay can enumerate, and the real responsibility of the state's entire profession rests with the following three roles: (1) organized medicine —the state and county committees on occupational health should continue to offer more leadership with their recommendations passed through the State Medical Society's channels to the advisory committee on workmen's compensation and to the state executive and legislative branches, (2) inter-society groups—specialty medical organizations should make available to the State Medical Society their direct assistance for such matters as the formulation of authoritative statements on causation and rehabilitation, and for continuing medical-legal education [participating organizations should be the Wisconsin chapters of the American College of Surgeons, the American College of Physicians, the Society of Internal Medicine, the American Academy of Family Physicians, the Industrial Medical Association, and other groups intimately involved in these areas such as the Regional Medical Program, the Governor's Committee of the President's Committee on Employment of the Handicapped and the Wisconsin Heart Association], and (3) Wisconsin academic centers—these centers should continue to promote and emphasize a greater awareness of occupational health, medical jurisprudence, and forensic medicine as part of the totality of undergraduate and graduate comprehensive medical education.

Lastly, as the House of Delegates of the AMA stated in its report on *Medical Relations in Workmen's Compensation: A Guide for the Evaluation and Implementation of a Progressive Program by the Medical Profession:* "The Council on Industrial Health wishes to emphasize again the importance of participation by physicians, individually and collectively, in a critical appraisal of medicine's past performance and its present opportunities for the implementation of new and creative concepts in workmen's compensation." The implication of this message is of great significance since it strikes at the heart of the current problem in workmen's compensation—lack of implementation. Will the medical profession meet the challenge? □

UW Family Practice Residency Is Growing . . . May Be Duplicated

A program working with the state's family physicians to train more family physicians for the state—this describes in a nutshell the University of Wisconsin Family Practice Residency.

Its faculty is composed primarily of family physicians and its focus is on training residents to meet the needs of rural Wisconsin communities.

Approaching its first birthday in July, the program now has five residents. Starting July first there will be 14—10 first-year residents, 2 second-year and 2 third-year. The following year the total number is expected to grow to 30—12 residents in each of the first and second years and six in the third year. In 1974, it is expected that the program will be filled in Madison, with 12 residents in each year.

The program's director, John H. Renner, MD, says this is as large a program as he wants in Madison. However, he hopes to see it duplicated by affiliation elsewhere around the state. Physicians, hospital administrators and health planners from Green Bay, Wausau, and Eau Claire have all expressed interest in affiliating with the program.

Independently, other Wisconsin communities are developing plans for residency programs. Milwaukee's St. Michael Hospital's residency program in Family Practice began last summer under the full time direction of Norbert G. Bauch, MD.

"It would be a terrible waste not to use again what we have learned here," Dr. Renner says. He says any large hospital with a high quality program that wishes to participate will be seriously considered.

The philosophy of the program, as Dr. Renner puts it, is that "a family physician ought to be able to take care of the usual things that precipitate a visit to the doctor very well."

To teach residents to do this, the program has established a clinic—the Family Practice Clinic—where the training is centered. Designed along the lines of a typical small town clinic, it is housed at present in Madison in quarters formerly used by nuns at St. Marys Hospital Medical Center.

The clinic has its own patients, an average population of Madison families. As the program grows it is expected new clinics will be opened elsewhere so that each teaching and service facility will remain like a small community practice.

"We want to keep the training situation similar to one which can be carried out by a solo practitioner or from 5 to 20 physicians," Dr. Renner says.

The continuing care of a group of patients and the emphasis on office practice are the most unique features of the program. Less emphasis is placed upon the traditional service rotation in training. The object is to give the residents a realistic approach to what they will do in practice. This is reflected in the three purposes of the residency program—teaching, service, and research.

In *teaching,* the model Family Practice Clinic focuses on family oriented health care within the community structure. It utilizes a multi-disciplinary approach involving physicians, nurses, social workers, physician's assistants, pastoral counselors, and other paramedical team members. Although most of the health care is supplied by this team, there are other medical specialists available to the clinic for consultation where indicated or desired.

In *service,* the stress is on providing health and illness care to both adults and children of Madison area families. Services are also available for family counseling. This is based on the belief that good health care is most effective when it includes all family members as a unit. Patients are expected to make periodic health evaluation visits as well as illness visits. Prevention of illness is a major goal as is patient health education.

In *research* the residents are encouraged to investigate health care delivery systems with the family physician as the primary care agent. One project in which all residents are currently participating is modification of problem oriented records to make recording patient care data easier and allow the details of this care to be more accessible.

Another project involves analysis of problem lists compiled by the residents. Such lists are the start of a long-term program which will help compare the various problems experienced in practices throughout the state.

On the basis of studies done elsewhere it is known that there is a tremendous variation from place to place. A physician commonly structures his practice to meet the needs of his area. As more is learned about various family practices throughout the state, it will aid the program in preparing physicians to serve these areas. The postgraduate medicine program has been a pioneer in practice profile studies in the state and problem oriented record keeping will help further refine those studies.

Research also is encouraged on problems which directly affect the health of a region. Dr. Renner

puts it this way: "If there is a severe environmental problem in the area, physicians may work for years just to keep up with the effects of it. Clearly it would do more good to get at the source of the problem."

Residents will be encouraged to utilize the resources of other University of Wisconsin departments and multidisciplinary institutes such as the Center for Medical Sociology and Health Services Research. The Family Practice Program is currently cooperating with the Center in conducting a survey of physicians and patients on their attitudes toward the concept of the physicians' assistant.

The residency is structured with decreasing amounts of "teacher" supervision each year and increasing involvement in the Wisconsin community.

First year residents give primarily inhospital care for patients of the faculty family physicians and attending staff at St. Marys Hospital Medical Center. They also spend time in the model clinic every week following patients seen in the hospital. Additional time is spent in the Family Practice Clinic with the resident following his own patients, and in community health activities.

The second year resident is primarily office based. He sees his own patients under faculty supervision, with supervision decreasing as his skills increase. He accompanies and observes all patients that he refers for consultations. He admits his own patients to the hospital and cares for them under supervision. He is also expected to spend some time in community health activities.

The current plan for the third-year resident is somewhat flexible. The resident can supplement his experience where he and the faculty feel he needs it. Particular consideration will be given to assisting the resident in finding a community in which to practice and what he will have to do in that community.

The resident may elect to work for one to three months "in practice" with participating physician faculty in various areas of the state. This will enable him to become familiar with the state and various patterns of practice. This should ready him to pick his own area and style of practice on the basis of first-hand knowledge and to understand the problems faced by physicians in different areas.

To support this plan for matching physician and community, the Program's research associate has constructed and continually updates an enormous resource base of socioeconomic data on Wisconsin regions and communities. This data provides the bulk of information for constructing profiles on communities to which residents are attracted.

The program's current Madison faculty includes six assistant clinical professors and four clinical instructors.

Assistant clinical professors are: MDs Gerald J. Derus, Monona; Edward H. Kolner, James N. Moore, B. E. Stein, and Walter L. Washburn, Madison; and William T. Russell, Sun Prairie. All are certified by the American Board of Family Practice, as are Dr. Renner and assistant program director, Richard Shropshire, MD, Madison.

Clinical instructors are: MDs John G. Albright, Haldor P. G. Barnes, and Martin C. Havel, Madison; and R. F. Korbitz, Monona.

The program's heavy emphasis on involving residents in small town medicine is specifically aimed at relieving Wisconsin's physician shortage and improving the distribution of physicians throughout the state, particularly rural areas.

Dr. Renner cites studies showing that the state's greatest deficit is in family physicians—over 500 of them are needed.

"This need is so large we have to have realistic programs that will do something about not only numbers, but also distribution," he says.

Therefore, the program is structured to make it as easy as possible for its residents to go into practice in Wisconsin. During the second and third years of the program, residents utilize the data base in selecting a community in which to practice. They are given background in the organizational expertise necessary to make a new practice successful, such as familiarization with professional management consultation. The physician's spouse is consulted to make sure the physician will be practicing in a community satisfactory to his family.

Now that the program is underway and is known throughout the country, Dr. Renner spends a good deal of time interviewing applicants.

"I spent several hours per resident last year in interviews," Dr. Renner relates. He tries to make certain they really are committed to the idea of a family practice in Wisconsin. The residents are asked to bring their wives for the interviews also.

As the program grows, it is expected to develop into a separate department at the UW Center for Health Sciences. Its growth will include not only more residents and assistance to other family practice residencies in the state but also some involvement in teaching family medicine to UW medical students. □

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WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Commission Sparks Innovations for MD Education

Improvement of physician performance through continuing medical education and self-assessment to ensure the best quality of care for patients is the ultimate charge to which the State Medical Society's Commission on Scientific Medicine is committed.

This was clearly pointed out in a special report to the Council by the Commission chairman, Gerald J. Derus, MD of Madison, at the Council's May meeting in Milwaukee. The full report appears on page 29.

Dr. Derus' report indicated a significant, aggressive, new approach for the Commission's role in carrying out its future planning and implementation of programs for physician education.

The Commission met June 9 at Society headquarters in Madison at which time the special report was studied. The Commission also elected S. E. Sivertson, MD of Madison, as its chairman, succeeding Dr. Derus who concluded a five-year term on the Commission. Other Commission actions appear elsewhere in this issue.

MEDICAID PATIENTS IN NURSING HOMES

30-Day Visit Rule Clarified

Physicians need not visit their Medicaid patients in *nursing homes* every 30 days if they feel it is unnecessary. However, this does *not* apply to Medicaid patients in *extended care facilities* certified under Title 18, Medicare. Medicare patients must be seen no less frequently than once a month.

The controversial 30-day visit rule was clarified somewhat in recent correspondence between the U.S. Department of Health, Education, and Welfare (HEW) and the Wisconsin Department of Health and Social Services.

A letter last month from Donald F. Simpson, HEW Commissioner in the Chicago office, said the intent of the 30-day visit rule "is to assure that all nursing home patients requiring a 30-day visit are, in fact, seen by a physician. Arbitrary and universal application which would result in unnecessary visits by physicians is not intended. Therefore, where a physician has specifically indicated that a patient's condition does not require monthly visits, a written statement to this effect must be on file in the nursing home for each Medical Assistance (Title 19) patient.

According to Mr. Simpson's letter, three things should happen in cases where 30-day visits are not being made and there is no written statement from the physician that such visits are unnecessary. In these cases: (1) the nursing home administrator is required to show that he has made a valid attempt to get the physician to visit the patient; (2) the home must notify the State Department of H&SS of its difficulties; and (3) the patient must be told that he has a right to go to a facility where his need for skilled nursing home care can be met.

The HEW clarification letter notes that the Social Security Administration's interpretation of the 30-day rule is more stringent for extended care facilities certified under Title 18, Medicare. In these cases, the rule is to be applied to all patients.

Dr. D. J. Ottensmeyer, Marshfield, Named to Society's CMCP

David J. Ottensmeyer, MD, Marshfield, has been named to the State Medical Society's Commission on Medical Care Plans. The Commission, which includes both physician and non-medical members, directs the Society's WPS-Blue Shield Plan, as well as other health care programs including Medicare and Medicaid.

Dr. Ottensmeyer, a neurological surgeon, is president of the Marshfield Clinic. He joined the clinic in 1965. He also serves as clinical instructor in surgery at the University of Wisconsin, Madison.

A native of Superior, Dr. Ottensmeyer is a 1959 graduate of the University of Wisconsin Medical School. He served his internship and residency at University Hospitals in Madison.

JCAH Guidelines Reviewed at Wisconsin Workshop

"Medicine's answer to government control" is what one physician has called the new hospital accreditation standards which go into effect July 1.

A Wisconsin workshop sponsored by the Joint Commission on Accreditation of Hospitals (JCAH) to explain the new guidelines attracted over 250 physicians, hospital administrators, and others June 1–2. The workshop was held at the Chula Vista Resort, Wisconsin Dells, and was cosponsored by the State Medical Society of Wisconsin and the Wisconsin Hospital Association.

The program was the 40th such JCAH workshop, part of a nationwide series on the new standards, accreditation survey procedures, and guidelines for medical staff bylaws. After July 1 hospitals will be surveyed every two years instead of every three years.

The standards are explicit about the propriety of taking care of the patient, the patient's right to physical privacy, and his right not to be used for teaching or research purposes except with his consent.

They state that the patient has a right to know what is being done to him, why it is being done, and who is responsible for his case. It is stipulated that no one should be refused care because of his race, creed, color, or national origin, or because of the source of payment of his bill.

Some 320 experts in all areas of health care services put together the new standards. JCAH's Board of Commissioners then reviewed them before they were adopted. The Board is composed of appointees from four member organizations: the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the American Medical Association. W. B. Hildebrand, MD of Menasha currently serves on the Board.

Among the most severe threats to a hospital that is refused accreditation is the possibility of losing its right to participate in some government programs or the loss of its housestaff if the American Medical Association Council on Medical Education decides to withhold approval of the program for interns and residents.

One of the most important objectives of the Hospital Accreditation Program is to assure that hospitals and physicians aid each other in delivering the best possible patient care. To aid in the organization or a hospital medical staff, JCAH has published Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations, 1971. Two versions are available, one for departmentalized hospitals and the other for non-departmentalized hospitals.

Copies of either version, $3.25 each, should be ordered from the JCAH, 645 N. Michigan, Chicago, Ill. 60611. The guidelines provide suggested procedures to protect against arbitrary action regarding privileges.

Drug Abuse Treatment Program Funded

A special office to provide federal funding and support for drug abuse treatment was established March 21 when President Nixon signed into law the Drug Abuse Office and Treatment Act of 1972 (P.L. 92–225).

The new law establishes two new channels for dealing with drug abuse: a Special Action Office for Drug Abuse Prevention in the White House and a National Advisory Council for Drug Abuse Prevention.

Dr. Jerome Jaffe, director of the office, has been at work under executive authority in anticipation of this legislation. The legislation gives the office additional authority and funds for overall planning and policy for all federal drug abuse prevention programs.

The law also:

*Calls for increased attention to drug abuse treatment and prevention in community mental health centers and public health service facilities.

*Forbids refusal of treatment to drug abusers suffering from emergency medical conditions or they are refused solely because of their drug abuse. Hospitals which fail to comply can have federal funds withdrawn.

*Authorizes formula grants to the states in the following amounts:

FY 72	$15 million
FY 73	$30 million
FY 74	$40 million
FY 75	$45 million

Grants to states will be based on relative population, financial need, and need for drug abuse services. Each state would receive a minimum of $100,000 under this authorization. (Congressional action is needed to actually appropriate these funds.)

*Requires that each state, in order to receive federal funds must: (a) submit a state plan for carrying out its purposes and designate a single state agency as the sole agency for supervising the preparation and administration of the plan; (b) establish a review system of the single state agency's applications for federal funds; and (c) make provision for licensing or accrediting drug programs and facilities.

Dr. Louis Olsman to Represent Society

Wisconsin will be represented at the 32nd Annual AMA Congress on Occupational Health by Louis Olsman, MD of Kenosha. It will be held at the Drake Hotel in Chicago, Sept. 11–12. Dr. Olsman is chairman of the State Medical Society's Committee on Occupational Health of the Commission on Health Information.

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MANAGING EDITOR: Earl R. Thoyer, Secretary, State Medical Society of Wisconsin.

Special Report to the Council by the Chairman of the Commission on Scientific Medicine—May 1972

Having served five years on the Commission on Scientific Medicine, it seems appropriate to make a few comments relative to postgraduate education and the role of the State Medical Society in the wide variety of activities taking place in the medical community of Wisconsin. I am pleased to note that the Commission's proposal for changing the terms of office and structure of the Commission is being advanced by the Council to the House of Delegates. We believe this will strengthen the Commission and enable it to carry out a more coordinated program of continuing and postgraduate education.

The Commission is aware also that the Planning Committee of the Council is studying changes in the Constitution and Bylaws, and it suggests that early consideration be given to rephrasing the purpose of the Commission on Scientific Medicine so that its charge might more clearly indicate its responsibilities.

Our Commission has been impressed with the sincere efforts of the University of Wisconsin Committee on Postgraduate Education. We believe they are ready and willing to cooperate with and pursue our common goals relating to the education of physicians, both in researching the problem and solving it. The muscle and resources of the Extension Division and the Medical School make their thrust one to be felt by all.

Most recently a private foundation has awarded a grant of more than $300,000 to the University of Wisconsin and the Wisconsin Chapter of the American Academy of Family Physicians to identify physicians' individual learning needs and to plan educational programs for them. We believe that a much closer tie can and must be made between the State Medical Society's Commission on Scientific Medicine and these University bodies so as to coordinate our efforts and utilize each other's potential more fully.

We believe that the Commission should be authorized to study and recommend an accreditation mechanism to review and approve postgraduate or continuing education programs in Wisconsin. We believe the Commission should be authorized to act as a catalyst in implementing the AMA Physician Recognition Award program which in itself is a major contribution to the improvement of quality of health care by encouraging physicians to engage in that area of study most important to the treatment of their patients.

We believe the Commission should be instrumental in the process of initiating self-assessment of professional medical care standards by the profession, and with the results available from such a process undertake organized self-improvement programs.

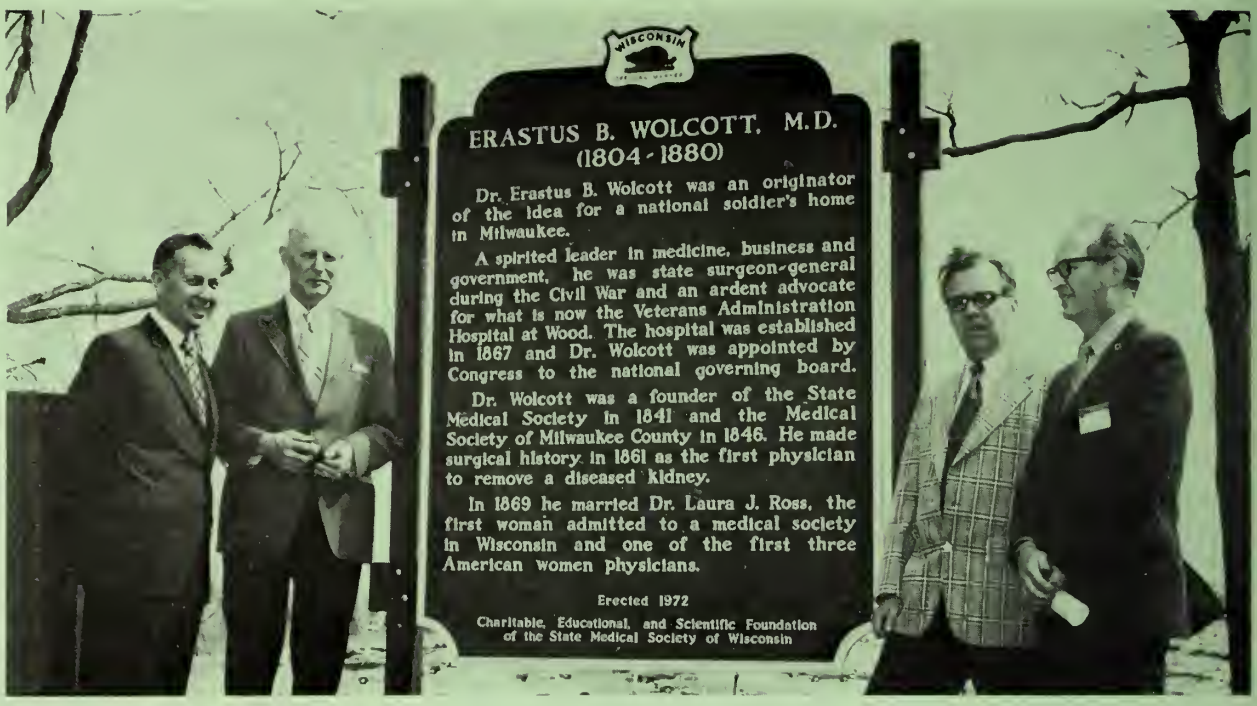
The Commission believes it is extremely urgent that the Medical Society, through this Commission and the staff, becomes deeply involved in the studies being undertaken by the Governor's Task Force on Health Planning and Policy. There are many within the Task Force structure who approach the problem of quality of health care in Wisconsin through the seemingly simplistic route of enforced postgraduate or continuing education utilizing legislation, licensure requirements, or something similar. Each of these has major shortcomings and would pose serious problems not only to the physician but to the public. For example, the Task Force has a subcommittee working on the education of health workers, and among its proposals is one to develop Area Health Education Centers. While this is currently only in the "working paper" stage, it will not move slowly and the Medical Society must become an important part of the planning for such an organizational structure. It is proposed that a model AHEC involve a consortium of programs and institutions within a health planning region, organized to provide educational opportunities, both preparatory and continuing, for health workers including physicians. I think it should be noted that at this stage in the development of the "working paper" provision has been made for representation from some 15 groups and agencies in the membership of an AHEC but no specific representation is provided for doctors of medicine. While this may seem incredible, it is first of all a clear sign that the medical profession must find ways to become more directly involved in such planning efforts so that they who are the object of the continuing education can have some voice in how it will be provided.

The Task Force is also developing a position paper on the effects of licensure, accreditation and certification of health education in Wisconsin, another area that impinges closely on the activities of the Society's Commission.

It seems clear also from materials being given publicity throughout the nation that the hospitals of this country intend to move directly into the matter of continuing education for members of their medical staffs, extending this educational activity to the point of supervision of the patient on an outpatient basis in the physician's office. These efforts are being made with the expressed intent of engaging the hospital in more direct control and peer review of the physician's services, whether they be performed in the office or the hospital.

For the past many years the Society's Commission on Scientific Medicine has concentrated its attention on postgraduate education and scientific programming through the Annual Meeting and "in depth" programs. To a large degree these have been done with excellence and good purpose. Our responsibilities, however, do not end with these two activities. They may, in fact, be only a modest beginning. Our relations with the University of Wisconsin Medical School and the Medical College of Wisconsin must be vastly expanded in terms of continuing education of the members of our Society. We must be ready and able to contribute effectively to the involvement of the University Extension services, the enlarged and merged University educational system, regional medical programs, comprehensive health planning, and a host of other agencies and health groups who have become immensely active in the field of continuing education. To do less will result in turning over continuing education to others than the Medical Society—a solution, of course, we do not believe would be wise.

This will involve not only better coordination and greater activity on the part of the physicians who comprise the membership of this Commission, but of necessity will expand the role and contributions of Society staff upon whom the Commission depends so much for information, liaison, initiative, and constructive leadership.—GERALD J. DERUS, MD, Chairman, Commission on Scientific Medicine



Participants in the May 10 dedication of a Wisconsin historical marker honoring the pioneering Wisconsin physician, Erastus B. Wolcott, MD, were: (left to right) William C. Matousek, MD, Chief of Staff, Wood Veterans Administration Hospital; E. Ralph Guentzel, Historical Marker Committee, Milwaukee County Historical Society; David J. Carlson, MD, President, Medical Society of Milwaukee County, and Robert T. Cooney, MD, President, Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

Wolcott Historical Marker Erected

A state historical marker honoring the pioneering Wisconsin physician, Doctor Erastus B. Wolcott, was dedicated by the State Medical Society May 10 during its Annual Meeting in Milwaukee. The marker, on the grounds of the Veterans Administration Hospital, Wood, was erected by the Society's Charitable, Educational and Scientific Foundation, (CESF).

The marker notes that Doctor Wolcott "was an originator of the idea for a national soldier's home in Milwaukee" and that he was a founder of the State Medical Society in 1841 and the Medical Society of Milwaukee County in 1846.

Doctor David J. Carlson, president of the Medical Society of Milwaukee County said at the unveiling ceremony that the medical societies were founded to fight medical opportunists and quacks. He said, "it is unfortunate that in spite of all the events that have taken place, quacks do still exist among us with legislative support and endorsement."

Others speaking at the ceremony were: Dr. William C. Matousek, chief of staff at the Veterans Administration Hospital; E. Ralph Guentzel of the Milwaukee County Historical Society's marker committee; Doctor Robert Cooney, Portage, CESF president; and Mrs. George Walcott, Milwaukee, a distant cousin of Erastus B. Wolcott, who died in 1880. Mrs. Walcott's husband is a cardiologist.

RESIDENT–INTERN PAPERS PROGRAM

1972 Annual Meeting
State Medical Society
May 9–11, Milwaukee

Winners

WILLIAM S. MIDDLETON AWARD: $100

JOHN H. MACINDOE, MD, Madison; Fellow, University Hospitals: *Hypothalmic Control of Pituitary Prolactin Secretion in Man*

HARRY BECKMAN AWARD: $100

K. P. GANESHAPPA, MD, Wood; Fellow, Veterans Administration Hospital: *The Effect of Glucagon on Jejunal Motility, Electrolyte and Water Absorption in Man*

Health Council Has First Lay Member

The first lay member to serve on the state Council on Health has been appointed by Governor Patrick Lucey. Sylvia Kaufman, De Pere, was selected to succeed Kenneth Mickle, MD, Green Bay.

The seven members of the Council are appointed by the Governor for staggered seven-year terms.

Mrs. Kaufman is past president of the Brown County Medical Auxiliary, a member of the Family Service Association of Brown County, on the board of the Civic Music Association of Brown County, and on the Neville Public Museum board.

The Council is an advisory group within the Department of Health and Social Services. Its function is to advise the Health and Social Services Board (the nine-member governing body of the department) and the Division of Health. The Council must approve all rules and appointments outside the classified service proposed by the State Health Officer before they can take effect.

BEST SCIENTIFIC EXHIBITS

1972 Annual Meeting State Medical Society May 9–11, Milwaukee

GUNNAR GUNDERSEN GOLD MEDALLION AWARD

ROBERT J. FLEMMA, MD; G. W. BEDDINGFELD, MD; DERWARD LEPLEY, JR., MD; JACK C. MANLLY, MD; HOWARD J. ZEFT, MD; HENRY H. GALES, MD; H. DAVID FRIEDBERG, MD; W. DUDLEY JOHNSON, MD; ALFRED J. TECTOR, MD; JOHN A. WALKER, MD; DONALD R. MCRAVEN, MD; JOHN H. HUSTON, MD; FELIX E. TRISTANI, MD; RAMON L. LANGE, MD; and MICHAEL H. KEELAN, MD, Medical College of Wisconsin, St. Luke's Hospital, Veterans Administration Hospital, and Milwaukee County General Hospital, Milwaukee: *Aorto-Coronary Bypass Grafts—Early and Late Followup Studies*

SPECIAL MERIT AWARDS

- EDWIN L. BEMIS, MD; GEORGE H. LANE, MD; FRANK WALKER, MD; RUTH K. DUNHAM, MT (ASCP), with the assistance of MRS. HAZEL B. MAXWELL, KEN TRESTER, Public Relations; ROBERT FENN, Medical Illustrator, BRUCE RAYMOND, Medical Photography, Deaconess Hospital and Southeastern Wisconsin Sickle Cell Center, Milwaukee: *Mass Community Screening for Erythrocyte Abnormalities. Combined Testing of the Black Population in Milwaukee for Anemia, Sickle Cell Disease, G-6PD Deficiency and Lead Poisoning*
- JOHN HAMACHER, MD; MAXINE E. BENNETT, MD; SCOTT EWERS, DDS; DIANE M. BLESS, PhD; SHELDON ROSENTHAL, MD; ANDREW B. CRUMMY, MD; ELIZABETH BAEHR, RN; and STANLEY J. EWANOWSKI, PhD, University of Wisconsin Center for Health Sciences, Madison: *This Is Where the Action Is*
- WILLIAM B. HOBBINS, MD, FACS, FICS, Madison: *To Mammogram or Not—Five Years Practical Experience*
- ROGER C. WARGIN, MD and EDWARD KINSFOGEL, MD, St. Joseph's Hospital, Milwaukee: *Non-Inflammatory Cavitary Lesions of the Lung*
- ROBERT R. KOENIG, MD and MICHAEL J. SANFELIPPO, MS, Columbia Hospital, Milwaukee: *Thrombopathy*

SMS committees *in action*

Driver's License Standards. Commission on Safe Transportation, March 7, agreed that the state Department of Transportation should begin using a new driver's license application form containing questions on metabolic and cardiovascular-pulmonary diseases. It was suggested that the use of the form be reviewed every three months for the first year.

Learning Disabilities. Section on Ophthalmology, April 20, reported to the Division on Vision the Section's plans to sponsor an educational program on learning disabilities as related to vision. The program will be held in connection with the state meeting of the Wisconsin Education Association in October.

Mobile Eye Unit. Division on Vision, April 20, agreed to recommend that the Society give its support to the possible creation of a mobile eye unit in Wisconsin. These would be self-contained eye clinics staffed professionally by practicing Wisconsin ophthalmologists on a rotating basis working closely with local general physicians and ophthalmologists in the general geographic area who would be a point of referral for long-term care or surgical treatment.

Collection of Eyes for Eye Banks. Division on Vision, April 20, went on record in opposition to suggested legislation which would permit morticians to collect eyes for eye banks. The Section on Ophthalmology has previously adopted the same position in opposition to this proposal.

Occupational Noise Exposure. Division on Ear, Nose and Throat, May 26, agreed to correspond with all otolaryngologists and all industrial physicians in Wisconsin to determine if they will be willing to participate in and supervise audiometric testing programs under the law on Occupational Noise Exposure. The Division expressed the hope that all individuals active in industrial medicine would cooperate in this program. The Division also requested that the Society cooperate in sponsoring a one or two day training course on interpretation of audiograms for physicians willing to participate.

Audiometric Testing Programs. Division on Ear, Nose and Throat, May 26, requested that the Society endorse a training course for audiometric technicians which will be sponsored by the University of Wisconsin–Madison in August.

Pre-School Vision and Hearing Screening. Division on Ear, Nose and Throat, May 26, stated that it looks with favor on the progress being made in hearing testing for preschool children. It is encouraging physicians to cooperate and participate in the Department of Public Instruction's testing programs.

New Commission Officers. Commission on Scientific Medicine, June 9, elected Dr. S. E. Sivertson, Madison, chairman of the Commission, and Dr. N. O. Becker, Fond du Lac, general program chairman for the 1973 scientific meeting.

1973 Scientific Program. Commission on Scientific Medicine, June 9, approved a recommendation that the 1973 annual meeting scientific program be a two-day program. Dates for the entire meeting, including the House of Delegates, are March 25, 26, 27, with theme and topic for the scientific portion to be selected by a four-man subcommittee of the Commission chaired by Dr. N. O. Becker, Fond du Lac.

New CMCP Officers. Commission on Medical Care Plans, June 10, reelected MDs Robert Krohn, Black River Falls, vice-chairman; John T. Sprague, Madison, treasurer; R. A. Sievert, Madison, assistant treasurer; and D. N. Goldstein, Kenosha, and W. T. Casper, Milwaukee, delegates to the National Association of Blue Shield Plans.

Two Wis. Areas to Have Corps Physicians July 1

Two medical teams from the National Health Service Corps will be assigned to Wisconsin starting July 1. Menominee County and the Kickapoo Valley will each have a medical team on duty for at least two years.

Dr. Michael J. Reinardi, a family physician, will establish a practice based in Neopit. He is currently completing a family practice residency at Hennepin County Hospital in Minneapolis.

He will fill one of four health service positions authorized for Menominee County last January under the U. S. Emergency Medical Manpower Act of 1970. Plans call for a nurse and a health educator to be recruited locally. The fourth member of the team is to be a dentist.

Two physicians have been assigned to the Kickapoo Valley medical team. Dr. Douglas Collins is completing a pediatrics residency at University Hospitals in Madison. Dr. John Weiler has completed an internship in internal medicine at the University of Indiana in Indianapolis.

Both will be based in La Farge starting July 1. The now-empty La Farge Clinic will be their headquarters and will be renamed the Kickapoo Valley Medical Clinic. Other members of the Kickapoo Valley team are to be a dentist, a nurse, a medical technician, and a dental assistant.

Because of the geographical size of the Kickapoo Valley, plans call for the team to work regularly in other locations as well as La Farge. In the application submitted by the Western Wisconsin Health Planning Organization for the Kickapoo Valley residents, an additional nurse was proposed for supervision of screening services, utilizing a mobile van provided by the Community Action Program. The administration and medical staff of the Vernon Memorial Hospital, Viroqua, have offered to provide assistance and training if necessary.

Currently, the Kickapoo Valley contains about 10,000 residents and the only physician active there is Dr. W. A. Sannes, 70, Soldiers Grove.

Nine executive committee members and four officers were recently elected from the area to serve on the Kickapoo Valley Medical Services, Inc., which will handle the administrative duties for the team.

The government will fund both the Kickapoo Valley and the Menominee County teams for two years. After this time the communities served are expected to sustain teams. Don Parrot, associate planner for the Northeastern Wisconsin Health Planning Council, which is administering the Menominee County program, has said that extensions will be available if a system cannot be set up "whereby they can pay their own bills and the whole thing be self-sufficient."

Parrot said the Council is hopeful that medical services in Menominee County can be paid for in the future through the Medicaid program or some kind of national health insurance program for the needy.

Speakers at dedication ceremonies for the Nicholas Senn historical marker in Fond du Lac June 3 were (left to right): Robert M. Senty, MD, Sheboygan; David L. Lawrence, MD, Fond du Lac; William J. Schereck, Lodi; Donald Blakely, Fond du Lac; and Mrs. Kenneth Worthing, Fond du Lac.

Senn Marker Erected, Fond du Lac

Nicholas Senn, MD, the "great master of abdominal surgery," was honored with a second historical marker at ceremonies June 3 in Fond du Lac.

The first marker was at the site of his office in Milwaukee's West Side Bank building at the corner of North Third and Juneau streets. It disappeared in the path of a freeway eight years after it was erected in 1960 by the State Medical Society of Wisconsin and the Milwaukee County Historical Society.

The new marker is at the Galloway House complex, near where Dr. Senn went to high school in the early 1860s. Taking part in the dedication were Robert M. Senty, MD, Sheboygan, vice president of the Charitable, Educational and Scientific Foundation, and William J. Schereck, Lodi, supervisor of the Office of Local History, State Historical Society of Wisconsin.

Fond du Lac representatives at the ceremony were: David L. Lawrence, MD, president of the Fond du Lac County Medical Society; Mrs. Kenneth Worthing, chairman of research at the Fond du Lac County Historical Society; and Donald Blakely, president of the Fond du Lac County Historical Society.

Dr. Senn was the 49th president of the American Medical Association and one of Wisconsin's greatest surgeons, physicians, and medical pioneers.

Health Financing Symposium Set for August 17–18, in Green Bay

A symposium on Health Finance Mechanisms will be held Thursday and Friday, August 17 and 18, in Green Bay at the Beaumont Motor Hotel and University of Wisconsin–Green Bay.

Sponsored by the Northeastern Wisconsin Health Planning Council, the symposium will include subjects on traditional insurance (federal, commercial, and non-profit), health maintenance organizations, the Canadian National Health Insurance, and the national health insurance proposals.

Among the speakers will be John D. Valiante, HMO Project Manager of the Department of Health, Education, and Welfare; and H. L. Livergent, Chairman of the Board of Extendicare (Canada) Ltd.

Other speakers include: John J. Murphy, Director of the Wisconsin Medical Assistance Programs; James Y. Marshall, Health Insurance Council; Lloyd Mathwick, Employers Insurance of Wausau; Robert Haskins, Associated Hospital Services; Donald McIntyre, Wisconsin Physicians Service;

Floyd R. Detert, Marshfield HMO; Michael Troyer, University of Wisconsin, Health Economics; Betty P. Dooley, Health Security Action Council; Paul W. Earle, American Hospital Association; James Y. Marshall, Health Insurance Council; Malcolm O. Scamahorn, MD, American Medical Association; and Steven Kurzman, Deputy Assistant for Legislation, Department of HEW.

There is a registration fee of $15 which includes dinner only on August 17. An additional fee of $2 will be necessary for those not pre-registered. Registration is to be made with the Northeastern Wisconsin Health Planning Council, 828 Cherry Street, Green Bay, Wis. 54301 (registrants are asked to send a self-addressed business envelope).

Society's Annual Meeting Attendance: 1,737

Total attendance of the three-day scientific program, May 9–11, was 1,737.

Registration of physician members was 942, while the balance consisted of 116 physican guests, 74 interns-residents-medical students, 248 exhibit representatives, and 473 guests (certified nurses, physicians' wives, etc.).

The three sessions of the House of Delegates had the following registrations: 124 first session; 122 second session; and 104 third session. There are 142 voting members of the House.

Handicapped Schools Visited

Members of two divisions of the State Medical Society took a field trip April 27 for visits to the Wisconsin School for the Deaf at Delavan and the Wisconsin School for the Visually Handicapped at Janesville.

The Division on Handicapped Children and the Division on Ear, Nose and Throat of the Commission on State Departments have made this trip the past few years.

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PHYSICIANS WITH TWO OR MORE EMPLOYEES are subject to the Williams-Steiger Occupational Safety and Health Act of 1970, the Dept. of Labor has ruled. Under the act, each employer must display a poster supplied by the Occupational Safety and Health Administration. The poster cites provisions of the law, responsibilities of employees and employers, and penalties. Physicians with two or more employees must also keep a log of occupational injuries and illnesses (OSHA Form 100), a supplementary record of injuries and illnesses (OSHA Form 101), and a summary of injuries and illnesses (OSHA Form 102). Form 102 must be posted where employees can see it. AMA attorneys said employers are not required to submit the forms but must have them available for inspection by the Dept. of Labor. Posters, forms, and information may be obtained from OSHA regional offices. A physician's guide to the law was prepared by the AMA's Council on Occupational Health and published in the February 14 issue of JAMA.

IF YOU HAVEN'T POSTED SIGN REQUIRED UNDER PHASE II ECONOMIC GUIDELINES, you are urged to do so. Sign advising patients that a list of base prices for principal services is available for examination must be posted "in a prominent place." Those failing to comply are subject to a $5,000 fine upon conviction for willful violation. IRS agents have been making spot checks of physicians and dentists in various parts of the country and spot checking is expected to be stepped up now that income tax deadline has passed and more personnel are available. All State Medical Society members were sent a sign and brief Phase II information in early February. Physicians still needing a sign can obtain one by contacting the State Medical Society. "Principal services" that MDs must list in their schedule of base fees have finally been defined by Price Commission. It said principal services "are those which comprise 90% of the annual revenues." It is not necessary, however, to list any service for which the charge is $5 or less. Any change from the base fee must be noted in the fee schedule.

DUES-PAYING MEMBERS OF THE SOCIETY are reminded of the $10 special assessment levied by the House of Delegates in May to step-up and continue the Society's efforts to oppose expansion of the cult of chiropractic, with emphasis on public education. The one-time assessment is mandatory in fulfilling a member's 1972 dues requirement. Only life members are exempt from the special assessment, since they are exempt from all dues payments as stipulated in the Bylaws.

AAFP CREDIT OF FIVE HOURS (prescribed) for each day's plenary session May 9 and 10 at the 1972 Annual Meeting of the State Medical Society in Milwaukee will be given those physicians who attended, it has been announced by James N. Moore, MD, the state education chairman for American Academy of Family Physicians. Notification of attendance should be made immediately to the Wisconsin Academy of Family Physicians, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

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SECTION OPHTHALMOLOGY

JUNE 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

ANNUAL MEETING OF SECTION

The annual meeting of the State Medical Society's Section on Ophthalmology met May 11 for a luncheon and business session at the Sheraton–Schroeder Hotel in Milwaukee. Elmer E. Johnson, MD of Madison, Section chairman, conducted the meeting which preceded the scientific program being held in conjunction with the State Society's annual meeting.

George H. Anderson, MD of Stevens Point, reporting on the Section's finances, stated that the expenses for the year as of March 31, 1972, were $1,952.64 with a balance in the treasury of $11,089.94.

James V. Bolger, MD of Waukesha reported on his investigation into the proposed mobile eye unit for the state. He remarked that he had had much correspondence with various leaders in the field in the country to get their views on the procurement of such a unit which would be used in rural and inner city areas. It was his feeling that such units could be serviced professionally by ophthalmological residents from both medical schools and some general practitioners and ophthalmologists. He said there are two active units in Florida, one in New Jersey, and one in Quebec, Canada, at the present time. A committee was appointed to continue the investigation of mobile units.

Doctor Bolger also made a plea for members of the Section to become members of the American Association of Ophthalmology. He outlined the many functions and accomplishments of the Association.

Doctor Johnson reported on the Learning Disabilities Conference he attended in Atlantic City last fall. He stated that he has been contacted by the Wisconsin Education Association to establish a panel for a discussion of dyslexia and learning disabilities at the fall meeting of the Education Association. He reported that the Association has requested that a film be developed by the Ophthalmology Section to be presented at the next annual meeting of the State Medical Society. Doctor Johnson felt that there should be panels, including ophthalmologists, established throughout the state at various educational sites such as Green Bay, Eau Claire, Stevens Point, etc. to confer with the faculties of the various universities that are dealing with communicative disorders.

Doctor Johnson reviewed the Rhode Island Ophthalmological Society plan to test the legality of the Rhode Island Optometric Act which was enacted July 15, 1971. This Act enlarges the definition of optometry and authorizes optometrists in the examination or diagnosis of the human eye to ascertain the presence of abnormal conditions or functions to use the topical application of drugs to the eye including mydriatics, miotics, and topical anesthetics for the purpose of detecting any disease or pathological condition of the eye or the effects thereof, all without medical training, direction, or supervision. The Section agreed to take $1,000 from the treasury to be contributed to the Legal Defense Fund of the R. I. Society.

The question of the proposed optometric school for the University of Wisconsin–La Crosse was discussed. The Section agreed to use $2,500 from its treasury to employ an individual to study the feasibility and need for such a school.

Doctor Johnson reported that a questionnaire will be sent to all ophthalmologists and optometrists in the state to determine the current status of the coverage of eye care in response to the survey, "How Should Ophthalmology and Eye Care Be Delivered?" There are 15 areas in the state to be covered.

George Nadeau, MD, Green Bay, reported for the State Medical Society's Division on Vision.

The nominating committee, headed by Samuel Blankstein, MD, Milwaukee, reported the following slate of officers for 1972–1973 with all being unanimously elected: chairman, W. Carson Parks, MD, Milwaukee; chairman-elect, George H. Anderson, MD, Stevens Point; secretary-treasurer, Herbert Giller, MD, Milwaukee; delegate, Duane Mings, MD, Monroe; alternate delegate, Gordon Backer, MD, Wausau.

UW ORTHOPTICS TEACH-IN

Mrs. Aleatha Tibbs Rapoport will be a guest speaker at the University of Wisconsin July 21 and 22. She has made significant contributions to the field of orthoptics over the past 20 years, both as a teacher and in the clinical area. She was chief orthoptist at the New York Eye and Ear Infirmary until recently.

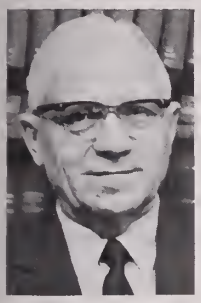
Those who wish to attend should contact Dale Blanche, orthoptist, or Thomas France, MD, Department of Ophthalmology, University Hospitals, Madison, Wis. 53706; tel. 608/262–1477. □

NEWS HIGHLIGHTS

Dr. Otto A. Mortensen Retires in June

After spending a lifetime demonstrating to University of Wisconsin—Madison students that anatomy isn't static, Otto A. Mortensen, MD* will retire this month although he anticipates serving as a visiting professor at Stanford University for a year.

"Obviously the structure of the human body hasn't changed during the 45 years that I have taught anatomy," he says, "but our knowledge and interpretation of its structure has grown apace with the advancement of the other biological sciences." Doctor Mortensen believes the advent of the electron microscope which permits magnifications of cell structure up to 500,000 times or more, has probably been the single most significant event in anatomical sciences during the period of his career.



Dr. Mortensen

A Milwaukee native, Doctor Mortensen received all of his degrees at Wisconsin. After receiving the MD in 1929 and serving a one-year internship, he returned permanently in 1930 as an instructor in anatomy. He was promoted to full professor in 1946 and was chairman of the Department of Anatomy from 1950–1967. He was assistant medical school dean from 1949–1952 and associate dean from 1952–1967.

During his tenure on the faculty Doctor Mortensen has served as a consultant to the National Board of Medical Examiners, the National Institutes of Health, and to the University of San Marcos in Peru. At the state level he was a member of the Governor's Education Advisory Committee for many years and since 1967 has served on the Educational Approval Board.

He was vice-president of the American Association of Anatomists from 1960–1962 and was recipient of the State Medical Society of Wisconsin's Distinguished Service Award in 1967. In 1969 Doctor Mortensen was named chairman of the State Medical Society's new Committee on the Shortage of Physicians. He served on the board of directors of Madison General Hospital from 1953–1970, and since 1968 has been president of its educational and research foundation.

Wisconsin Surgical Society

New officers of the Wisconsin Surgical Society elected at the Annual Meeting May 11 in Milwaukee are: president, Wayne Boulanger, MD,* Milwaukee; president-elect, Wilson Weisel, MD,* Milwaukee; secretary-treasurer, P. Richard Sholl, MD,* Janesville; recorder, John D. Conway, MD,* Milwaukee; and councilors, George Pratt, MD,* Rhinelander, and Bruce Stoehr, MD,* Green Bay.

Society of Hospital Management Engineering

A new professional Society of Hospital Management Engineering was established in Milwaukee. The society has brought together a diverse group of professionals working in the health care field, reported Mohan Kirtane, director of systems at St. Mary's Hospital in Milwaukee. Harold Farkas of St. Joseph's Hospital, Milwaukee, and Mr. Kirtane were elected the first president and vice-president respectively. Mrs. Janet Buck of Mt. Sinai Medical Center, Milwaukee, is the secretary. The society's objective is to bring about economies and improvements in health care delivery systems in general and hospitals in particular, Mr. Kirtane stated.

PHYSICIAN BRIEFS

M. W. Stuessy, MD*

. . . Brodhead, recently was presented the "Outstanding Citizenship Award" by the county chapter of the UW Alumni. Doctor Stuessy retired from the school board this year after serving 27 years, most of them as president. He has practiced medicine in Brodhead for 34 years, has served as president of the Wisconsin Health Council, Green County Medical Society, and has served as chief of staff at St. Clare Hospital.

Helen C. Young, MD*

. . . Greenfield, recently resigned as county medical examiner of Milwaukee County effective May 20. Doctor Young has been with the examiner's office since 1958. She is an assistant professor and chairman of the Department of Pathology and Oral Pathology at the School of Dentistry at Marquette University.

Roland C. Brown, MD*

. . . Wauwatosa, resigned as assistant medical examiner for Milwaukee County effective May 5. He had worked part-time in the medical examiner's office for nearly six years. He plans to devote full-time to his specialty of pathology. He is pathologist for Lutheran Hospital of Milwaukee and is associated with a private laboratory.

Fu-Che Liao, MD

. . . Marshfield, recently became a member of the medical staff of the Marshfield Clinic. Doctor Liao graduated from the University of Taiwan Medical School in 1961 and interned at Schenectady, New York. He did residency work at St. Michael's Hospital, Newark, N. J., and also at Cleveland, Ohio. Prior to joining the Marshfield Clinic, he was a staff physician at the Virginia Training Hospital in Lynchburg, Va.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

PHYSICIAN BRIEFS . . .

Abraham B. Schwartz, MD*

. . . Milwaukee, recently was presented the annual William C. Frye Community Service award of the Milwaukee Foundation given by the First Wisconsin Trust Co. As a pediatrician, Doctor Schwartz has contributed in many ways to the development of Milwaukee Children's Hospital and the Medical College of Wisconsin. He is medical coordinator of the Via Marsi Montessori School for Retarded Children, a member of Children's Hospital mental health committee and the child development committee of Easter Seal Society, a member of the Kearney Committee for Negro Welfare, a consultant to the Uhrig Foundation, and a volunteer pediatrician at the Guadalupe Children's Clinic.

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NEWS HIGHLIGHTS . . .

Fox Valley Academy of Medicine

The Fox Valley Academy of Medicine recently concluded another interesting and successful professional education program, according to Thomas Burrows, MD,* Appleton. He reported that Harold Levine, MD from the Cook County Hospital Department of Medicine presented some new insights into the problems of diagnosis and management of chronic pulmonary disease. John Opitz, MD of the University of Wisconsin Medical School presented an informative program regarding the recognition and underlying causes of congenital syndromes. John Mielke, MD* of Appleton presented a program on the current status of coronary bypass surgery being performed in the Fox River Valley with special emphasis on selection of patients and results to date. Marcus Key, MD, assistant surgeon general and director of the National Institute of Occupational Safety and Health, spoke on the increasingly important role of medicine in industry.

Membership in the Academy has increased to over 140 physicians from 14 communities in the Fox River Valley, Doctor Burrows stated. Officers during the 1971–1972 program year have been: Timothy Flaherty, MD,* radiologist from Neenah, president; Jerry Salan, MD,* general practitioner from Waupaca, vice-president; and G. Douglas Reilly, MD,* pediatrician, Neenah–Menasha, secretary-treasurer.

American Medical Sailing and Yachting Association Regatta

Several Wisconsin physicians, and some of them winners, participated in the first annual American Medical Sailing and Yachting Association Regatta in Clearwater, Fla., May 3–6, according to a report by Marvin J. Roesler, MD* of Fort Atkinson.

Approximately 75 physicians from all over the United States attended the race in the 25 Morgan-22 yachts donated by the Morgan Yacht Corporation. Physicians were assigned either three or four to each boat. There was one tune-up race on May 4, and two official races each on May 5 and 6. The winning team consisted of MDs Jerry Sutterfield (obstetrician–gynecologist, Atlanta), Bill Mize (OB–GYN, Sherman, Texas), and Pete Davoisin (cardiologist, Chattanooga, Tenn.). Second place went to Marvin Roesler, MD (radiologist, Fort Atkinson, Wis.) with crew consisting of daughter, Diane, age 17, and son, Paul, age 14, representing the Delavan Lake Yacht Club. Third place went to a team consisting of Don Flitman, MD (ophthalmologist, Miami, Fla.), Joe Carlisle, MD (general practitioner, Belvidere, Ill.), also a member of the Delavan Lake Yacht Club, Wisconsin, and Gerald O'Brien, MD (OB–GYN, Minneapolis), who sails out of Bayfield, Wis., on Lake Superior.

Other Wisconsin physicians included MDs John Flanary (OB–GYN, Wauwatosa), who sailed with a team consisting of MDs Francis Vincent (GP, Lake Springfield, Ill.), and Jim Wovell (GP, Keokuk, Iowa). They finished in the top 10. A former Madison, Wis., resident, Richard Plater, MD, also finished in the top 10.

The regatta was arranged in cooperation with *RX Sports and Travel* magazine and the Windjammer's Yacht Club of Clearwater. Headquarters was the Clearwater Point Hilton. Other regatta activities included a tour of the Morgan Yacht Corporation in St. Petersburg, dinner at the Kapok Tree Inn, dog races, Hawaiian luau at the Hilton, and regatta awards banquet at the Hilton.

Physicians interested in joining the American Medical Sailing and Yachting Association may do so by contacting James D. Telfer, MD, President, AMSYA, RX Sports and Travel, 447 South Main Street, Hillsboro, Ill. 62049.

PHYSICIAN BRIEFS . . .

C. Norman Shealy, MD*

. . . La Crosse, director of the pain rehabilitation center at St. Francis Hospital, recently presented a scientific exhibit on "Rehabilitation of the Chronic Pain Patient" at the American Association of Neurological Surgeons in Boston.

Darold A. Treffert, MD*

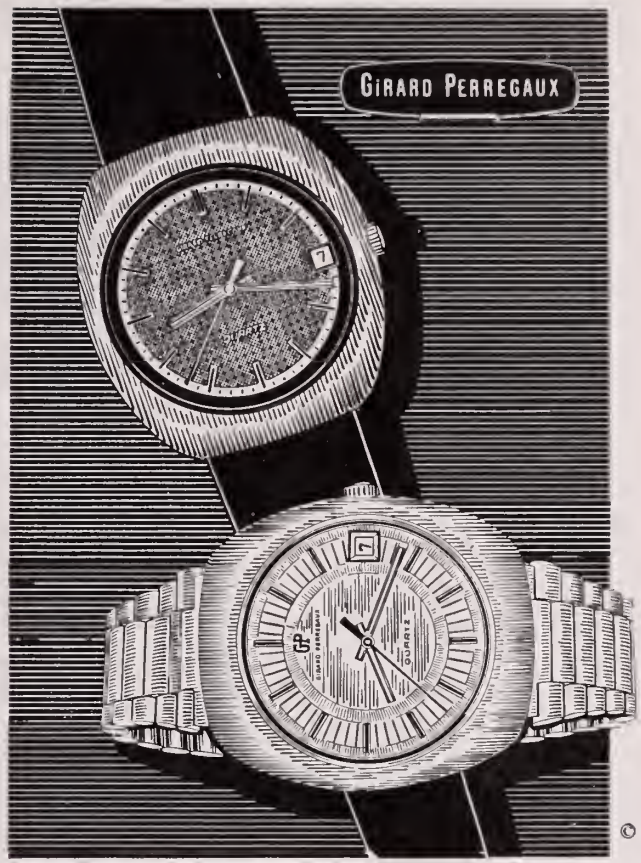
. . . Fond du Lac, superintendent of Winnebago State Hospital, recently was named "Man of the Year" for 1971 when the delegate assembly of the Wisconsin Association for Mental Health met at the State Medical Society of Wisconsin, Madison. Doctor Treffert was cited for his work in obtaining public support for mental health programs.

Thomas C. Meyer, MD*

. . . Madison, associate dean of the University of Wisconsin Medical School, recently was appointed chairman of the Association of American Medical College's (AAMC) continuing education planning committee.

Ernest W. Reynolds, MD

. . . recently was appointed director of the cardiovascular section of the Department of Medicine, University of Wisconsin Health Sciences Center, Madison campus. A professor of internal medicine (heart section) at the University of Michigan, Doctor Reynolds assumed his Wisconsin position in May, succeeding the late Charles Crumpton, MD. The new director also will be teaching medical students and house officers at the center, serve as attending physician for part of the year on the medical service of the University and Veterans Administration Hospital, and pursue his research and clinical interests. Doctor Reynolds holds a BS in chemistry and an MD (1946), both from the University of Oklahoma. A former president and secretary of the cardiac electrophysiological group of the American Federation for Clinical Research, he joined the Michigan faculty in 1952.



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PHYSICIAN BRIEFS . . .

Rafael S. Saladar, MD

. . . Beloit, recently became associated with the medical staff of the Beloit Clinic. A graduate of Santo Tomas in the Philippines, he served a rotating internship at Augustana Hospital, a general practice residency at Louis A. Weiss Memorial Hospital and a general surgical residency at Illinois Central Hospital, all in the Chicago area.

R. M. Baldwin, MD*

. . . Beloit, in April was recognized as one of the top recruiters in the country of new members to the Association of American Physicians and Surgeons during its meeting in Chicago. He is a Wisconsin delegate to the national Association.

MEETINGS AND SPECIAL EVENTS HELD AT THE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1972

1 University of Wisconsin Hospital Board
1 Dane County Medical Society Insurance Advisory Committee
2 Educational Program on Diabetes for Health Professionals
2 Dane County Medical Society Board of Trustees, Delegates and Alternates
2 Madison Urological Society
2 Madison Anesthesiology Society
6 Wisconsin College Health Association
8 *SMS Annual Meeting (Milwaukee)*
9 *SMS Annual Meeting (Milwaukee)*
10 *SMS Annual Meeting (Milwaukee)*
11 *SMS Annual Meeting (Milwaukee)*
17 State Pharmacy Board Exams
19 Wisconsin Nutrition Council
21 SMS Division on Nervous and Mental Diseases
24 Madison Chapter, National Association of Accountants
25 Madison Academy of Internal Medicine
26 SMS Division on Ear, Nose and Throat

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

NEWS HIGHLIGHTS . . .

Dr. Urben Receives UW Medical Alumni Citation

Walter J. Urben, MD,* the man who made Wisconsin's Mendota State Hospital one of the most outstanding institutions of its type, was honored at his alma mater May 26.

Doctor Urben received the 15th Alumni Citation at the University of Wisconsin Medical School Alumni Day in Madison. He retired as superintendent of Mendota in March 1970 and resides in Shorewood Hills.

Doctor Urben was selected for the honor by the Medical Alumni Board of Directors from a list of alumni who have made outstanding contributions to medicine compiled by emeritus professors. The selection was later approved by the medical school faculty and UW—Madison Chancellor Edwin Young.

Dr. Urben

During his 21 years as superintendent of Mendota, Doctor Urben brought widespread improvements to facilities, patient care and treatment to the 673-bed state mental hospital. When he took over in 1948 only four or five physicians were available to treat over 800 patients in a single, large structure just northeast of Madison.

Today, the 100-year-old facility has been replaced by modern patient buildings, and a medical staff of 31 treats 670 patients. Under his leadership, the hospital became a training facility for psychiatrists, nurses, social workers, theology students and other professionals. Mendota also was one of the first mental institutions in the country to open its doors to the community and to participation of volunteers in its program.

A native of Monticello, southwest of Madison in Green County, Doctor Urben was graduated from the University of Wisconsin Medical School in 1930. He served his internship at Ancker Hospital in St. Paul, Minn., and then went to Ohio where he worked in state and private mental hospitals for nine years.

Returning to Wisconsin in 1940, Doctor Urben became a staff physician at Mendota State Hospital. He left in 1943 to become director of the State Division of Mental Hygiene and resigned that position in 1948 to return to Mendota as superintendent.

Though hampered somewhat by failing eyesight, Doctor Urben is still active as an examiner for Dane County, as a utilization board member for two local nursing homes, and he recently went on a leave of absence from the VA Hospital at Tomah, where he served as a consultant for several days each month.

Colon Clinic to Memorialize Vince Lombardi

The Medical College of Wisconsin recently announced that it intends to establish a Colon Clinic memorializing Vince Lombardi at Milwaukee County General Hospital, the College's principal hospital affiliate. The new clinic will be made possible through the Medical College's share of proceeds from this year's Vince Lombardi Golf Classic, which is scheduled for June 23–24 at the North Hills Country Club in Milwaukee.

Last June the first annual Lombardi classic at North Hills attracted 160 golfers who were friends and admirers of the late coach. The $20,000 raised was equally shared by the Vincent T. Lombardi Cancer Research Center at Georgetown University Medical School, Washington, D. C., and the Milwaukee Division of the American Cancer Society. The Georgetown school will share this year's proceeds with the Medical College of Wisconsin.

NEWS HIGHLIGHTS . . .

Jerome J. DeCosse, MD, PhD,* who has had a leading role in the clinic's planning, said that the MCW share of tournament proceeds will be used to buy equipment and provide supportive staff for the clinic's medical-surgical team. He said a major objective of the clinic will be research that can lead to a better understanding and management of patients with colon and rectal cancer and precursors of these diseases. Doctor DeCosse is professor and chairman of MCW's Division of Surgery and director of surgery at Milwaukee County General Hospital.

Another objective of the clinic will be to broaden the education of medical students and resident physicians in the field of cancer. Doctor DeCosse said that among proposed research studies to be carried out under clinic staff direction will be ones relating to radiological diagnosis of colon cancer and polyps and motility studies of colon cancer; genetics studies of colon cancer; cell kinetic studies; and investigations of carcino-embryonic antigens.

Deaconess Hospital Intern–Extern Resident Alumni Association

The current management of heart patients was the discussion topic at the fourth annual meeting of the Deaconess Hospital Intern-Extern-Resident Alumni Association May 13 in Milwaukee.

Speakers included MDs James T. Botticelli,* cardiologist and chief of medicine at Deaconess; Albert H. Pemberton,* cardiovascular surgeon; internists Raymond L. Rice* and John J. Smith,* and Frank G. Stergiades,* panel moderator.

An evening dinner-dance at the Milwaukee Athletic Club capped the annual affair. The association is composed of some 100 former interns, externs, and residents of the hospital.

PHYSICIAN BRIEFS . . .

Enrique W. Luy, MD*

. . . Wild Rose, recently became associated with the Wild Rose Clinic. Doctor Luy took his internship at St. Francis Hospital, Pittsburgh, Pa., St. Luke's in New York, and at Cancer Memorial Hospital. He spent 18 months in surgery internship at Michael Reese Hospital, Chicago. Doctor Luy practiced in Sharon prior to joining the Clinic.

Roger Petersen, MD*

. . . representing the Walworth County Medical Society, appeared in May on a panel discussing "Emergency Medical Services" during an open meeting of the Walworth County Health Planning Committee in Elkhorn. The panel discussion was part of the health planning committee's aim to provide the community with an open forum to discuss current health issues, according to Margaret Hatfield, MD, local committee president.

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Stephen B. Webster, MD*

. . . dermatologist at Gundersen Clinic, Ltd., La Crosse, and assistant clinical professor of the University of Wisconsin Medical School, Madison, in May addressed the 14th International Congress of Dermatology at the Medical College of Padua, Padua–Venice, Italy. His subject was "The Febrile Ulceronecrotic Form of PLVA (Pityriasis Lichenoids et Varioliformis Acuta)."

James H. Brandenburg, MD*

. . . associate professor and chairman of the Department of Otolaryngology, University of Wisconsin Medical Center, Madison, was initiated into the American Society for Head and Neck Surgery at the Society's annual meeting April 26 in Palm Beach, Fla.

Ovid O. Meyer, MD*

. . . who retired as professor of medicine at the University of Wisconsin Medical School in 1971 after 40 years on the UW medical faculty, was presented the Emeritus Faculty Award of the UW Medical Alumni Association at its annual Alumni Day May 26 in Madison. Doctor Meyer is the thirteenth recipient of the Award.

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H. David Friedberg, MD

. . . has been appointed to the Medical Advisory Board of Cardiac Pacemakers, Inc. of Minneapolis, Minn. He is to be concerned with the design and development of a new pacemaker using as a power source the lithium–iodide cell invented by Mr. Wilson Greatbatch of New York. This power source is expected to have an extremely long, useful life, Doctor Friedberg noted.

Renato T. Faylona, MD

. . . Wisconsin Dells, recently became associated with MDs F. W. Gissal,* and H. L. Conley,* at the Dells Clinic. Doctor Faylona graduated from the University of Santo Tomas Medical School, Manila, The Philippines, and served his internship at Deaconess Hospital, Milwaukee. A four-year surgical residency was spent at St. Joseph's Hospital, Milwaukee, and then a return to The Philippines for two years of practice as a general surgeon. Prior to arriving at the Dells Clinic he was at St. Joseph's Hospital in Milwaukee.

Bruno Balke, MD

. . . professor of physical education at the University of Wisconsin–Madison, received the American College of Sports Medicine's highest citation, its honor award, at the College's annual meeting May 2 in Philadelphia, Pa. Doctor Balke, widely known as a physiologist and physician, was cited "as a careful investigator, international authority on sports medicine, a dedicated fellow and past-president of the College who still finds time to set an example of life-long participation in healthful exercise." Director of the University of Wisconsin's Bio-dynamic Laboratory, Doctor Balke has contributed significant research effort in the areas of body stresses in sports and high altitude activity, exercise devices for physically handicapped persons, sports performance, space medicine, and functional capacities of aging persons. He joined the Madison campus faculty in 1964.

Theodore C. Feierabend, MD*

. . . and his wife, who is a nurse, are medical missionaries currently on furlough in Madison. They have spent the past 4½ years at the Christian Medical College, Ludhiana, Punjab, India, under appointment by the United Church Board for World Ministries. Doctor Feierabend, a plastic surgeon and fourth generation missionary to India, has been speaking to United Church of Christ audiences while in the United States.

Glenn S. Custer, MD*

. . . past president of the Marshfield Clinic, in May spoke at a House committee hearing in Washington, D. C. to tell about the early experience of the Greater Marshfield Health Plan serviced by the Clinc and St. Joseph's Hospital. Doctor Custer also is immediate past president of the American Association of Medical Clinics.

Herbert W. Pohle, MD*

. . . Milwaukee, was reelected to serve as the governor of his area of the American College of Physicians at the ACP's annual meeting recently held in Atlantic City.

Calvin J. Gillespie, MD*

. . . Hales Corners, recently was installed as a fellow of the American College of Obstetricians and Gynecologists at its 20th annual meeting held in Chicago.

Vaughn Demergian, MD*

. . . of the Jackson Clinic and Methodist Hospital medical staffs in Madison, was honored by Greater Madison Chamber of Commerce at its 10th annual Police Recognition luncheon, May 18. He was cited by the group for his treatment of city and county policemen injured in street riot duty, and for his training of road officers in the handling of accident victims before arrival at hospitals. A specialist in plastic and reconstructive surgery, Doctor Demergian is a graduate of the University of Wisconsin Medical School.

NEWS HIGHLIGHTS . . .

Sickle Cell Anemia Screening Funded for Madison

The Division of Health, Wisconsin Department of Health and Social Services, has agreed to provide the Madison Urban League with up to $4,500 toward a citywide screening program for sickle cell anemia and the sickle cell trait among persons who are Black or of Black ancestry.

Services to be rendered include information, screening, follow-up counseling with persons having positive tests and referral to other services, the Division reported.

The funds for this particular program will come from the Division's Federal formula grant under Public Law 90–248—Social Security Amendments of 1967, Title V, Maternal and Child Health Services.

The agreement, valid to Dec. 31, 1972, binds the Division to reimburse the League on a monthly or quarterly basis for the amounts actually expended for screening and counseling services—not to exceed $4,500. The Division will also provide consultation in the conduct of the program.

In turn, the League agreed to make available educational materials, conduct a citywide screening program and arrange for counseling services. In addition, the League will supply a progress report at the conclusion of the program and quarterly itemized expenditure and activity reports with vouchers or other referral numbers.

Services are to be rendered in compliance with Title VI of the 1964 Civil Rights Act, the Division stated.

Society's Surgery Section Names Officers

New officers of the State Medical Society's Section on Surgery are as follows: chairman, Wayne J. Boulanger, MD,* Milwaukee; secretary, P. Richard Sholl, MD,* Janesville; delegate, Thomas Beno, MD,* Green Bay; and alternate delegate, George Pratt, MD,* Rhinelander. They were elected during the State Medical Society's annual meeting in Milwaukee in May.

Great Plains Organization for Perinatal Health Care

Doctors and nurses in obstetrics and pediatrics in a six-state region—Iowa, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin—met in Minneapolis, Minn., May 22–24, to exchange their knowledge and experiences in efforts to reduce infant mortality in the midwest and to assure better quality of life for those who survive.

The annual meeting of the Great Plains Organization for Perinatal Health Care was the first regional action by medical professionals in the United States to encourage development of regional perinatal centers to serve pregnant women, their fetus and their newborn infants, to coordinate education of health care personnel and to foster preconceptual and interconceptual education of future parents.

The organization's president, Pediatrician Dr. J. Michael Hartigan* of the Gundersen Clinic, La Crosse, Wis., estimates that one defective or retarded child may cost society as much as one-half million dollars in a forty-year lifetime.

Fourteen perinatal centers are already in operation in the region—Des Moines, Dubuque, and Iowa City, Iowa; Minneapolis and St. Paul, Minn.; Lincoln and Omaha, Neb.; Sioux Falls, S.D.; Green Bay, La Crosse, Madison, Marshfield, Milwaukee, and Neenah, Wis.

New centers are under development in Waterloo, Iowa; Duluth and Rochester, Minn.; and Fargo and Grand Forks, N.D. □

PHYSICIAN BRIEFS . . .

Werner E. Langheim, MD*

. . . Madison neurosurgeon, discussed "Head Injuries" at the April meeting of the Jefferson County Medical Society at Meadow Springs Golf Club.

Julius T. Gericke, MD*

. . . has been appointed emergency room physician for Sacred Heart Hospital, Eau Claire, effective June 1. He replaces James K. Martins, MD who resigned April 30. A graduate of Macalester College and Marquette medical school, Doctor Gericke interned at Miller Hospital in St. Paul, Minn. He served three years as a physician in the Navy, and spent seven years in Glenwood, Minn., prior to coming to Eau Claire in 1953. He practiced with John W. Lowe, MD until 1965 when Doctor Lowe retired. A general practitioner, Doctor Gericke also has been active in the amputee clinic in Eau Claire.

Hania W. Ris, MD

. . . Madison pediatrician and director of the Wisconsin School for Girls at Oregon as well as a clinical instructor at the University of Wisconsin Medical School, was presented the Humanitarian Award 1972 during the second annual awards event by the Wisconsin Zero Population Growth (ZPG) May 3 in Madison. Doctor Ris was praised as an "unusually gifted, unusually energetic, and unusually effective" advocate of health care measures that would improve the quality of life. She has been active on committees of the American Academy of Pediatrics and the Society for Adolescent Medicine, and she has been dubbed the "Nader of VD in Wisconsin" for her work in venereal disease detection and treatment.

Ernest F. Freymiller, MD*

. . . Boscobel physician for 42 years, recently announced his retirement. Doctor Freymiller graduated from the University of Wisconsin in 1919 and completed his work for a medical degree from the University of Minnesota in 1922. □

OBITUARIES

Harold B. Keland, MD, 87, Racine physician for over 50 years, died Jan 17, 1972, in Racine.

Born on May 2, 1884, in Norway, Doctor Keland graduated from the Wisconsin College of Physicians and Surgeons (now the Medical College of Wisconsin) in 1912 and served his internship in Milwaukee. He served as chief of staff of St. Luke's Hospital and was on the staff of St. Mary's Hospital. In 1963, Doctor Keland was inducted into the "50 Year Club" of the State Medical Society of Wisconsin.

He also was a member of the Racine County Medical Society and the American Medical Association.

Surviving is a son, W. H. Keland of Racine.

Samuel J. Leibenson, MD, 65, Oshkosh, died Jan. 30, 1972, in Oshkosh.

Born on June 21, 1906, in Lithuania, Doctor Leibenson graduated from Rush Medical College, Chicago, in 1933 and served his internship and residency at Milwaukee County General Hospital.

He was a member of the Wisconsin Academy of Family Physicians, Winnebago County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Mae; two sons, Ronald and Dennis, California; and one daughter, Mrs. Geoffrey Catlin, Neenah.

Gilbert J. Schwartz, MD, 75, former Kenosha physician for 47 years, died Jan. 31, 1972, in Palm Harbor, Fla.

Born on July 19, 1896, in Grundy Center, Ia., Doctor Schwartz graduated from Rush Medical College, Chicago, in 1922 and served his internship at Presbyterian Hospital, Chicago. He began his medical practice in Kenosha in 1924 and retired in 1971. Doctor Schwartz served as chief of staff at Memorial and St. Catherine's hospitals in Kenosha and was a member of the Wisconsin Academy of General Practice.

He was a past president of the Kenosha County Medical Society, a member of the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; a son, Donald F., Wilmette, Ill.; two daughters, Mrs. Tom (Jean) Dobbins, Palm Harbor, Fla., and Mrs. Ron (Dorothy) Berg, Dunedin, Fla.

Frank W. Pope, MD, 91, prominent Racine physician, died Feb. 2, 1972, in Racine.

Born on Nov. 23, 1880, in Racine, Doctor Pope graduated from Rush Medical College, Chicago, in 1903 and worked at Winnebago State Hospital for two years before joining his father in practice. He studied in Vienna in 1913 and served in the United States Army Medical Corp in World War I.

Doctor Pope was a councilor for the State Medical Society of Wisconsin from 1927 to 1939 and in 1953, the Society honored him for his 50 years in the practice of medicine. He was a former chief of staff at St. Mary's Hospital and was an honorary member of St. Luke's Hospital in Racine.

Doctor Pope served as president of the Racine County Medical Society and was a member of the American Medical Association.

Surviving are two sisters, Rosa M. Pope and Mrs. George (Eleanor) Goepfert, both of Racine.

William P. Glisch, MD, 71, Milwaukee physician for 46 years, died Feb. 10, 1972, in Milwaukee.

Born on Aug. 29, 1900, in Milwaukee, Doctor Glisch graduated from Loyola University Medical School, Chicago, in 1925 and served his internship at St. Mary's Hospital in Kansas City, Mo. Doctor Glisch was a member of the staffs of St. Luke's and St. Francis Hospitals in Milwaukee.

He was a member of the American Academy of Family Physicians, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Kathryn, and a daughter, Mrs. Shirley Fitzgerald of Greendale.

Michael F. P. Nightingale, MD, 46, Madison, died Feb. 13, 1972, in Madison.

Born on Mar. 10, 1925, in London, England, he graduated from the University of Wisconsin Medical School in 1968 and served his internship at Wayne County General Hospital in Michigan.

There are no immediate survivors.

William H. Towne, MD, 90, Hortonville, died Feb. 23, 1972, in Appleton.

Born on Sept. 22, 1881, in Waupun, Doctor Towne graduated from Marquette University School of Medicine (now the Medical College of Wisconsin) in 1907. He spent one year at the Grand Army Home, King, before opening offices in Shiocton in 1908. He practiced there for 21 years and for the past 43 years in Hortonville. He was the eldest practicing physician in Outagamie County. In 1955, Doctor Towne was chief of staff of the New London Community Hospital, and in 1957 he became a member of the "50 Year Club" of the State Medical Society of Wisconsin. He also was a member of the Outagamie County Medical Society and the American Medical Association.

Surviving is a daughter, Mrs. Gerald Jolin, Lakewood.

Donald M. Willison, MD, 54, Eau Claire, died Feb. 13, 1972, in Eau Claire.

Born on July 25, 1917, in Milwaukee, Doctor Willison graduated from the University of Wisconsin Medical School in 1941 and served his internship at University of Iowa Hospital. In 1942, Doctor Willison became associated with the Midelfort Clinic in Eau Claire. He served as chief of staff of Luther Hospital and also was on the medical staff of Sacred Heart Hospital. Doctor Willison served on the State Medical Society of Wisconsin's Commission on Public Relations and Communications for nine years including three years as its chairman. He was a member of the American College of Surgeons, the Eau Claire–Dunn–Pepin County Medical Society, and American Medical Association.

Surviving are his widow, Margaret; two daughters, Mrs. Jerald Ritsch, Eau Claire, and Mrs. Susan Golle, Minneapolis.

Frances Johnson, MD, 82, Milwaukee, died Mar. 9, 1972, in Milwaukee.

Born on Feb. 11, 1890, in Ireton, Iowa, she graduated from Rush Medical College, Chicago, in 1923, and served her internship at St. Francis Hospital, Evanston, Ill.

Doctor Johnson was a member of The Medical Society of Milwaukee County, State Medical Society

of Wisconsin, and American Medical Association.

Surviving is a sister, Miss Dorothy Johnson, Milwaukee.

Lawrence W. Hargarten, MD, 53, former Milwaukee physician, died Mar. 17, 1972, in Oakland, Calif.

Born on May 5, 1918, in Milwaukee, he graduated from Marquette University School of Medicine in 1943 and served his internship at St. Joseph's Hospital in Milwaukee. He served in the medical corps of the United States Navy during World War II. Doctor Hargarten practiced in Milwaukee until 1969 when illness forced him to retire and he moved to California.

He was a past president of the Catholic Physicians Guild, a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, and was a diplomate of the International Academy of Proctology.

Surviving are his widow, Margaret; a son, Mark; three daughters, Patricia, Cheryl and Laurel; and three stepdaughters, Mrs. Michael McCarthy, Oakland, Calif.; Mrs. Fred Howe, Brookfield; and Mrs. William Landreth, San Francisco, Calif.

Hansford Dorsey Nester, MD, 64, Eau Claire, died Apr. 1, 1972, in Rochester, Minn.

He was born in Ohley, W. Va., on Dec. 30, 1907. From 1920 to 1926 he was a student in the Greenbrier Military School at Lewisburg, W. Va., from which he received a high-school diploma. Having received a bachelor of arts degree in 1931 and a bachelor of science degree in 1934 from West Virginia University, he was admitted to the junior medical class at the University of Maryland School of Medicine, which granted him the degree of doctor of medicine on June 6, 1936. From July 1936 to July 1937, he was an intern in the Baltimore City Hospital. He then practiced industrial medicine in Cedar Grove and Mammoth, W. Va., until 1941.

He went to Rochester, Minn., in October 1941 as a fellow in pediatrics in the Mayo Graduate School of Medicine. His graduate sequence was concentrated on pathology (at the University of Minnesota Medical School), pediatric diagnosis, preventive pediatrics, and hospital pediatric service. He left the Mayo Graduate School of Medicine on Dec. 30, 1944, to enter the Medical Corps of the United States Naval Reserve. He was released to civilian life in 1947, and he then became a consultant in pediatrics at the Midelfort Clinic in Eau Claire.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, State Medical Society of Wisconsin, American Medical Association, and the Alumni Association of the Mayo Graduate School of Medicine.

Surviving are his widow, the former Rosalin Baker of Pikesville, Md.; and two daughters, Mrs. Don Elwood of Twin Lakes, and Mrs. Fred Cavanaugh, Wilmington, Del.

Henry A. Sincock, MD, 85, Superior physician for 49 years, died Apr. 9, 1972, in Duluth, Minn.

Born on May 21, 1886, in Ishpeming, Mich., Doctor Sincock graduated from Northwestern University Medical College in 1911 and served his internship at St. Luke's Hospital, Chicago, Ill. A veteran of World War I; he served as a government doctor for the Bad River Indian Reservation in Odanah and was instrumental in ending the last big epidemic of smallpox on the reservation in Wisconsin.

Doctor Sincock started practicing in Superior in 1923 and served as the first chief of staff for Superior Memorial Hospital of which he was one of the founders. In 1932 he was named to the Superior Hall of Fame and was the recipient of the Outstanding Citizen of the Year award in 1961, sponsored by the B'nai B'rith.

Doctor Sincock aided in establishing the Douglas County Child Guidance Center, was a member of the Hospital Advisory Council and the State Board of Nursing. He was a member of the State Medical Society's first Council on Scientific Work, chairman of the Division on Crippled Children, and member of the 50 Year Club of the Society.

He was a past president and member of the Ashland–Bayfield–Iron County Medical Society, Northwestern Pediatric Society, Wisconsin Obstetrical Society, Interurban Academy of Medicine, and Douglas County Medical Society. He also was a member of the American Medical Association.

Surviving is his widow, Gwen.

Charles Benkendorf, MD, 49, Green Bay, died Mar. 11, 1972, in Green Bay.

Born on June 19, 1922, in Milwaukee, Doctor Benkendorf graduated from Marquette University School of Medicine (now Medical College of Wisconsin) in 1946 and served his internship at Milwaukee County General Hospital. He practiced in Monticello for six years before moving to Green Bay in 1957. He served in World War II and the Korean War.

Doctor Benkendorf was chief of the radiological service at St. Vincent Hospital, Green Bay, and served on the staff of the Shawano Hospital. He was a member and past president of the Wisconsin Radiological Society and of the Wisconsin Medical Alumni Association. He was formerly a member of the Commission on Medical Care Plans of the State Medical Society of Wisconsin and was an assistant clinical professor in the Department of Radiology at the University of Wisconsin Medical School, Madison.

Doctor Benkendorf was a fellow in the American College of Radiology and a member of the North American Radiological Society, Brown County Medical Society, and American Medical Association.

Surviving are his widow, Ruth; two daughters, Anne and Mary; and a son, Chuck, Green Bay. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MAY 18, 1972

NEW MEMBERS

Arsenovic, Alexander, 619 Center St., Prentice 54556
Barton, Michael, 208 Parker St., Boscobel 53805
Cassidy, George E., 20 South Park St., Madison 53715
Chopra, P. S., 1300 University Ave., Madison 53706
Desai, Jitendra N., 1300 University Ave., Madison 53706
Dvorak, Paul F., 5921 Hemstead Rd., Madison 53711
Hansen, Raymond A., 620 North 19th St., Milwaukee 53233
James, John R., 733 West Clairemont Ave., Eau Claire 54701
Jovanovic, Dusan, 1300 University Ave., Madison 53706
Keeler, William H., 2388 North Lake Dr., Milwaukee 53211
Mabini, Francisco M., Jr., 5301 Eastway St., Apt. 1, Greendale 53129
Matallana, Raul H., 1300 University Ave., Madison 53706
Pineda, Honorio G., 821 Wilson St., Menomonie 54751
Rich, Frederick M., 110 East Main St., Madison 53703
Swartz, Harold M., 8700 West Wisconsin Ave., Milwaukee 53226
Till, Eugene W., 2900 West Oklahoma Ave., Milwaukee 53215
Torczynski, Elise, 929 North Astor St., Milwaukee 53202
Yeni-Komshian, Haig H., 1300 University Ave., Madison 53706
Zondlo, Joseph G., 900 South Webster Ave., Green Bay 54301

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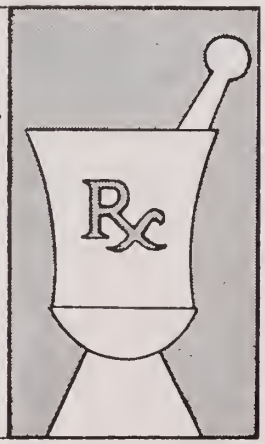

CHANGE OF ADDRESS

Albrecht, Donald J., 5757 West Oklahoma Ave., Milwaukee 53215
Bachhuber, Michael W., 410 Short St., Mayville 53050
Bennett, William H., 222 Wolff St., Racine 53402
Bertelson, James N., 6610 Berkshire Rd., Madison 53711
Bonell, Blair T., 3618—8th Ave., Kenosha 53140
Brightbill, Frederick S., 1025 Regent St., Madison 53715
Cron, Roland S., 7740 North River Edge Dr., Milwaukee 53209
Dempsey, Kenneth J., N88 W16624 Appleton Ave., Menomonee Falls 53051
Doty, John W., 1001—2nd St., West, Ashland 54806
Erbes, John, 2105 East Newport Ave., Milwaukee 53211
Faber, Samuel J., 133 South Laskey Dr., Beverly Hills, Calif. 90212
Foster, Lawrence L., P. O. Box 172, Elm Grove 53122
Gladstone, Herman P., 801 South Prudence Rd., Tucson, Ariz. 85710
Headlee, C. Raymond, P. O. Box 207, Elm Grove 53122
Hilker, Harold C., 828 Blaine Ave., Racine 53405
Huston, Erwin S., 231 West Michigan St., Milwaukee 53203
Johnson, Elmer S., 1117—21st St., Monroe 53566
Kim, Soo Y., 3527 Oakwood Dr., Racine 53406
Lambert, Joseph W., Rural Route 1, Box 69, Elcho 54428
Larkin, Watson B., 2119 Heights Dr., Eau Claire 54701
Limjoco, Uriel R., W213 N5349 Adamsdale Rd., Menomonee Falls 53051
Lipscomb, Charles R., 1580 Highland Dr., Elm Grove 53122
Manesis, John G., 943—11th St., S.W., Rochester, Minn. 55901
Mayersak, Jerome S., P. O. Box 232, Merrill 54452
McCandless, Edward E., 230½—3rd St., Wausau 54401
McClelland, G. Bruce, 1543 North 116th St., Milwaukee 53226
Meighan, Pearse P., 1818 North Mead, Appleton 54911
Miller, Wallace C., P. O. Box 156, Muscoda 53573
Morrow, Cecil A., 5405—82nd St., Kenosha 53140
Perssion, Leo B., 2771 Dudley Dr., East, Apt. G, West Palm Beach, Fla. 33406
Pratt, George F., 1020 Kabel, Rhinelander 54501
Redlin, Russell R., P. O. Box 631, Elm Grove 53122
Reichle, Robert I., 720 East Wisconsin Ave., Milwaukee 53202
Reyes, Jose E., Jr., 911—16th St., Racine 53403
Saketos, Theodore P., 666 North 74th St., Wauwatosa 53213
Schneiders, Edwin F., 19 Fuller Dr., Madison 53704
Seefeld, Philip H., 2105 East Newport Ave., Milwaukee 53211
Shockley, Benjamin F., Jr., P. O. Box 593, Elm Grove 53122
Sholtes, Clause A., 1208 Charles St., Fort Atkinson 53538
Simons, Neal S., 1897 Lincoln St., Whitehall 54773
Slutzky, Nathan, 5000 West National Ave., Wood 53193
Spiegelhoff, Don R., 9203 West Bluemound Rd., Milwaukee 53226
Strube, Roger H., 308 Fairview Ave., South Milwaukee 53172
Szymarek, Joseph E., 2029A West Mitchell Ave., Milwaukee 53204
Tasche, John A., 4211 Birch Dr., Sheboygan 53081
Turner, C. Randolph, 7335 Maple Terr., Milwaukee 53213

DEATHS

Maercklein, Arthur G., nonmember, Apr. 21, 1972
DeWitt, Robert J., Marinette-Florence County, Apr. 25, 1972
Rueth, John E., Milwaukee County, Apr. 25, 1972
Kocovsky, Elmer C., Milwaukee County, Apr. 26, 1972
Larsen, Lawrence L., Milwaukee County, May 1, 1972
Borsack, Karl K., Fond du Lac County, May 6, 1972
Wolf, Robert C., Milwaukee County, May 10, 1972
Weisfeldt, Simon C., Milwaukee County, May 13, 1972 □

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

CHANGING PATTERNS OF BACTERIAL INFECTIONS AND ANTIBIOTIC THERAPY

Proceedings of the Excerpta Medica Symposium by Warner-Chilcott Laboratories, Morris Plains, N. J. 07950. Editor, Harold C. Neu. 1971. 193 pages.

THE ESOPHAGOGASTRIC JUNCTION

Proceedings of the Excerpta Medica Symposium by Warner-Chilcott Laboratories, Morris Plains, N. J. 07950. Editors, David Katz and Fredric Hoffman. 1971. 167 pages.

MYOCARDIAL ISCHEMIA

Proceedings of the Excerpta Medica Symposium by Warner-Chilcott Laboratories, Morris Plains, N. J. 07950. Editors, Richard S. Ross and Fredric Hoffman. 1971. 124 pages.

DIAGNOSIS AND TREATMENT OF COMMON THYROID DISEASES

Proceedings of the Excerpta Medica Symposium by Warner-Chilcott Laboratories, Morris Plains, N. J. 07950. Editors, Herbert A. Selenkow and Fredric Hoffman. 1971. 129 pages.

CODE FIVE

By Frank G. Slaughter, Doubleday & Company, Inc., 277 Park Ave., New York, N. Y. 10017. 1971. 249 pages. Price: $5.95

BARRINGTON

By John Rowan Wilson. Doubleday & Company, Inc., 277 Park Ave., New York, N. Y. 10017. 1971. 312 pages. Price: $6.95

MODERN TREATMENT, VOLUME 8, #2

Advances on Treatment of Some Common Neurologic Disorders, Guest Editor, William L. Griggs, III. *Diagnosis, Mechanisms and Treatment of Hemolytic Anemias*, Guest Editors, Lawrence S. Lessin and Wendell F. Rosse. Medical Department, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. $20.00 per year. Published bi-monthly. May 1971.

BOOK REVIEWS

TEXTBOOK OF NUCLEAR MEDICINE TECHNOLOGY

By Paul J. Early, Muhammad A. Razzak, MD and D. Bruce Sodee, MD. The C. V. Mosby Company, Saint Louis, Mo. 1969. 378 pages. Price: $15.50

This book appears to be suitable for nuclear medicine technologists trained specifically in the field of nuclear medicine. It is less suitable for X-Ray technicians unless they intend to continue specializing in the field of nuclear medicine and are willing to undergo some further training.

It is perhaps of most value to physicians at the resident level who may wish to spend a rotation in the nuclear medicine field. Its emphasis is on currently available scanning and other imaging techniques. The more familiar brain, liver, lung, and spleen scans appear to be adequately characterized. The studies relating to the urinary system radionuclide therapy are rather abbreviated.

The bibliography and glossary are adequate. The whole volume is suitably indexed.

In summary, I believe this book should be included in the library as an introductory reference book.—IAN TYSON, MD

INSTRUCTIONAL COURSE LECTURES

By The American Academy of Orthopaedic Surgeons. The C. V. Mosby Company, St. Louis, Mo. 1970. 236 pages. Price: $19.50

As the title indicates this volume is not a treatise on one theme, but a collection of 13 lectures on varied topics. These topics range from the detailed biochemistry of articular cartilage to the "hammer and saw" operative treatment of unstable intertrochanteric fractures of the femur.

Other papers of note include an excellent summary of current knowledge on fat embolism and a striking documentary of the true incidence of thromboembolic disease with evidence to document that the incidence may be decreased with proper treatment.

Helpful information is offered on the proper bracing for patients with acquired spasticity. A concise paper clears up many mysteries of electrodiagnostic studies. The proper treatment of war wounds is presented in a very convincing fashion.

The information in this volume is a written version of material presented at the 1969 annual meeting of the American Academy of Orthopaedic Surgeons. For the last nine years this material has been published in the *Journal of Bone and Joint Surgery*. The Academy feels it is more desirable to have this material available in one volume "especially for the physician in training."

The articles, contributed by capable and well recognized authors, are predominantly review articles. Little controversial material is presented. They are intended to rapidly convey recent pertinent knowledge to the practicing physician.

It is the opinion of the reviewer that the majority of this volume is worthwhile reading for anyone engaged in the practice of orthopedic surgery.—ANDREW A. MCBEATH, MD

DRUG SEMINAR

By Winnebago State Hospital. 1970. 60 pages. Price: $1.00

"Drug Seminar" is a compilation of talks given at a two-day seminar held in September 1970 at Winnebago State Hospital. The seminar was designed to attract professional people who have to deal with drug abuse problems and the audience probably included, beyond physicians and nurses, persons in social work, clinical psychology, and similar fields related to mental health.

A good portion of the volume has a sociological orientation which is presented as two opposing viewpoints: the "establishment" and the "counter culture." I found this the most interesting part of the book and recommend it to physicians who live in their own "ivory towers" and for whom an insight into "street pharmacology" might prove stimulating, if not vertiginously intoxicating. For example, Mr. Hurrle, one of the seminar panelists, says, ". . . In the drug culture there are guys known as testers—really strong people in terms of ability to handle drugs—and a big dealer has to be one of these guys because he doesn't want to take his customers or give them bad stuff. There is a lot of bad stuff running around. . . ." Mr. Hurrle thus implies that there is a certain "good faith" among big dealers in the illegal drug market place. This

contrasts with an experience of the reviewer who was told by a dealer (and user) that because of the amount of bad stuff going around, he never uses a drug himself until he first tries it out on some other person. This Borgia-like dealer was perhaps not a big dealer but a small dealer!

Dr. Darold A. Treffert, Superintendent of the Winnebago State Hospital, contributed a well-thought-out piece entitled, "See Me, Feel Me, Touch Me, Heal Me." The point of his talk was the truism that he had coined earlier, ". . . the mischief does not lie in drugs at all, the mischief lies in people." Physicians can learn much from this essay.

The remainder of the volume deals in the main with what might be termed clinical pharmacology and includes first aid for the drug user, aspects of narcotics, stimulants, depressants, hallucinogens and cannabis, and a final section on legal outlooks. The material reviewed in these sections is quite up-to-date but the reviewer was plagued with the lack of proofreading following transcription of the talks from a tape recorder (presumably) to a typewriter. There is no Brill's *Pharmacology*, the text referred to is Drill's *Pharmacology in Medicine*. LSD was originally synthesized by Stoll (not Stall) at the Sandoz (not Sandoze) laboratories and the first inadvertent LSD trip was taken by Hofmann (not Hoffman). Of perhaps more import to the practice of medicine, is the uncertainty generated by garbled transcription of drug names and of terminology. On page 24 for example, Tholacine instead of Thorazine appears in parentheses as the proprietary name for chlorpromazine and the words coallergic and anticoallergic (properly cholinergic and anticholinergic) are found in the paragraphs dealing with belladonna alkaloid intoxication.

With the above noted reservation which speaks for recognition that the printed word with its permanence may on occasion be more than a simple recording of the spoken word, I recommend this small mimeographed volume as an introduction to drug abuse problems. It will be of heuristic value for professional people who have not yet encountered among their patients this aspect of social disquietude.—JOSEPH M. BENFORADO, MD

HERNIA REPAIR WITHOUT DISABILITY

By Irving L. Lichtenstein, MD. The C. V. Mosby Co., St. Louis, Mo. 1970. 210 pages. Price: $26.50.

This atlas presents the technique and the results of hernia repairs done by the author. The first chapter is a short precise historic resumé, followed by a very interesting chapter on the incidence and economic significance of hernia and hernia repair in the United States, in which the author makes a strong point for his "hernia repair without disability." This is followed by a chapter of surgical anatomy which is well done; and although the diagrams are in black and white, they are of excellent quality. He then discusses the etiology of inguinal and epigastric hernias. He discusses in detail the techniques of regional and local anesthesia.

The main portion of the book is a discussion of the author's surgical technique in repairing the inguinal hernia; he stresses several points that many surgeons will take issue with. He strongly favors hernia repair under local anesthesia; the repair having been accomplished, the patient is discharged from the hospital within 24 hours and returned to his normal activity. He does not use a Cooper's ligament repair, and in fact argues against it, favoring Poupart's ligament for his lateral attachment. Other points of controversy would be the routine use of a plastic mesh in all recurrent and direct inguinal hernias and the statement regards to sliding inguinal hernias that high ligation or reconstruction of the sac is unnecessary. One cannot argue with his results of an overall recurrence rate of 2.4%.

He concludes with a brief chapter on the dynamics of wound healing supporting prompt resumption of activity. I found the book extremely interesting and although I cannot agree with the author on several points, he presents another approach to the "hernia repair" in a very clear and concise way which certainly will make interesting reading for the beginner as well as the accomplished surgeon.—RICHARD J. JONES, MD

ATLAS OF OBSTETRIC TECHNIC

By J. Robert Wilson, MD, MS, The C. V. Mosby Co., St. Louis, Mo. 1969. 313 pages

This atlas combines several good teaching features with some standard pitfalls.

The section on normal delivery is generally good; however, on page 25, a common mistake is depicted: The lower hand is contaminated by the distended rectum. This maneuver should be performed as shown on page 29; i.e., with the operator's hands under the chin and the occiput respectively. Stripping of the umbilical cord is not routinely indicated as this has been shown to increase the likelihood of hyperbilirubinemia in premature babies and mature ones certainly do not need the extra blood.

The sections on anesthesia, episiotomy, perineal and cervical lacerations are quite good. Those on abnormal presentations, Cesarean section and hysterectomy are excellent.

The section on the third stage of labor is good; however, I disagree with the author's statement that the only indication for manual removal of the placenta is when the normal mechanisms for expulsion fail. There is good evidence that routine manual removal of the placenta is a safe procedure. I would strongly oppose uterine packing in the treatment of uterine atony. This is an ineffective hemostatic procedure and actually it might prevent the myometrium from contracting and thus achieve hemostasis.

The discussion on forceps is nearly complete although one wishes the author had devoted some time to the Barton forceps with which I think every obstetrician should be familiar.

On shoulder dystocia no new thoughts or techniques are presented. The author merely presents some standard text book explanations. He does not cover the technique of cleidotomy which I believe every obstetrician should know.

The section on destructive operations on the fetus is too meager and I believe more techniques could have been discussed. The discussion on placenta praevia is rather obsolete as it recommends such procedures as scalp traction and Braxton Hicks version.

The chapter on induction of labor is good; however, the author fails to recommend the use of the fetal monitor during the procedure.

In general, I do not think this atlas contributes any significant body of information or techniques. It seems adequate for medical students and interns to obtain general information about the conduct of labor and delivery as long as complementary supervision in the labor suite follows.—LOUIS B. CURET, MD

SUDDEN INFANT DEATH SYNDROME

By Abraham B. Bergman, J. Bruce Beckwith & C. George Ray, Editors. University of Washington Press, Seattle, Wash. 98105. 1970. 248 pages. Price: $10.00

Edited by Bergman, Beckwith and Ray, "Sudden Infant Death Syndrome" is a compilation of the papers and discussions of the Second International Conference on Causes of Sudden Death in Infants. In this conference there were twenty-seven participants and seven guests. Papers pre-

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sented by each participant are followed by discussions. The book is divided into six parts—Introduction, Epidemiology, Pathology, Virology, Physiology, and Summaries. At the end of the book appendices supply information on various international, national, and regional associations for support in research, and guidance for parents of victims of Sudden Infant Death.

This book brings up to date the present state of knowledge in this syndrome which has plagued investigators for many years. It has brought together in a single volume comprising 234 pages all the information which has accrued since the First International Conference held in 1963. Although much valuable data are now available this is all largely negative, in that neither mechanisms nor etiologic factors have been elucidated. It is certainly clear, particularly from the discussion, that although many hypotheses have been formulated, little concrete evidence is available to support the various suggested probabilities. Certain facts however are well established—the age incidence—almost invariably between one and five months of age, the very high incidence of death during the sleeping hours and the occasional familial occurrence. The routine pathological findings although extensively discussed are essentially similar in all groups studied and seem only to suggest a respiratory rather than a cardiac mechanism. The role of infection studied by many investigators is still very controversial as being implicated in any way, and the immunological aspects of the condition are ill defined. It would seem that the low incidence of SIDS in breast-fed infants has been long neglected in any exhaustive studies related to possible immunologic mechanisms, as first suggested by Stowens, but not even alluded to in this volume.

If the positive data were summarized, this volume could be contracted to a very few pages; however, it will no doubt be valuable to those specifically interested in sudden infant death and particularly to investigators who wish to pursue further avenues of investigation.—ENID F. GILBERT, MD □

Clinical Center Study of Patients with Cancer of the Oral Cavity, Pharynx, Larynx, or Paranasal Sinuses

The cooperation of physicians is requested in the referral of patients with cancer of the oral cavity, pharynx, larynx, or paranasal sinuses for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Md.

Patients selected for admission and treatment will be included in an adjuvant-therapy protocol where the treatment modalities of surgery, irradiation, and chemotherapy will be combined in such a manner as to determine the feasibility of such a therapeutic approach and its potential for decreasing the incidence of local recurrence and metastases.

Post-treatment studies are planned which will include cooperative followup between the referring physician and the National Cancer Institute.

Physicians interested in having their patients considered for admission to these studies may write or telephone: ALFRED S. KETCHAM, MD, Clinical Center, Room 10-N-116, National Institutes of Health, Bethesda, Md. 20014; tel.: 301–496–4164. □

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CAUTION: Federal law prohibits dispensing without prescription.
Indications: Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (*i.e.*, several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.
Contraindications: Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.
Warnings: When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
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Precautions: In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorexic agent and a restrictive dietary regimen.
Adverse Reactions: Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.
Dosage and Administration: The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.
Overdosage: Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.
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MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

July 15: Congress of Delegates Meeting, Wisconsin Academy of Family Physicians, at Midway Motor Inn, Wausau.

Aug. 17–18: Symposium on Health Finance Mechanisms, Northeastern Wisconsin Health Planning Council, Beaumont Motor Hotel and University of Wisconsin–Green Bay, Green Bay.

Aug. 28–Sept. 1: Emergency Care Course, American Academy of Orthopaedic Surgeons, at Madison. Course chairman: Kenneth M. Sachtjen, MD, 2715 Marshall Court, Madison, Wis. 53705.

Sept. 6–8: Tenth Annual Cancer Chemotherapy Conference, University of Wisconsin, Madison. Info: Dr. G. Ramirez, 714-C University Hospitals, Madison, Wis. 53706.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Internal Medicine, joint meeting with American College of Physicians, Holiday Inn, La Crosse.

Sept. 15–17: Annual Meeting, Wisconsin Radiological Society, Pioneer Inn, Oshkosh.

Sept. 19: Symposium on Primary Prevention of Heart Attack—Consumer Health Education, Hotel Pfister, Milwaukee.

Sept. 23: Cancer Conference, Marshfield Clinic Foundation for Medical Research and Wisconsin Division of American Cancer Society, Marshfield.

Sept. 23–24: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Oct. 6–7: Wisconsin Society of Obstetrics and Gynecology, Pioneer Inn, Oshkosh.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

1972 NEIGHBORING STATES

July 17–21: Institute on Hospital Design (simulated hospital planning), at American Hospital Association headquarters, Chicago, Ill.

July 21–22: Annual Session, North Central Region, American Association of Medical Clinics, Holiday Inn, Urbana, Ill. INFO: John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

Aug. 7–10: American Health Congress '72, Chicago–McCormick Place, Chicago, Ill. Info: Call Mrs. Ruth Blaine, 312/645–8220.

Oct. 14–20: Annual Otolaryngologic Assembly of 1972, Eye and Ear Infirmary of University of Illinois Hospital, Chicago, Ill. Info: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 13–18: Course in Laryngology and Bronchoesophagology, Department of Otolaryngology of Abraham Lincoln School of Medicine and University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill. Info: Dept of Oto., U of Ill. Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 24–25: Conference on Radiology in Otolaryngology and Ophthalmology, Chicago, Ill. Info: Galdino E. Valvassori, MD, Radiology Dept., Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Sept. 24–28: Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Convention Center, Dallas, Tex.

Oct. 2–6: Annual Clinical Congress, American College of Surgeons, Fairmont Hotel, San Francisco, Calif.

1973 NEIGHBORING STATES

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

* * *

Tenth Cancer Chemotherapy Conference. The Division of Clinical Oncology of the University of Wisconsin will hold its 10th Cancer Chemotherapy Conference September 6–8 at the Park Motor Inn, Madison. Conference is open to all United States physicians interested in cancer chemotherapy. It will review and present a forward look at anti-cancer therapy of solid tumors and leukemias as well as the role of radiotherapy, immunology and virology in the treatment of cancer.

Guest faculty: J. Palmer Saunders, PhD, director of Extramural Activities, National Cancer Institute, Bethesda, Md.; Loren J. Humphrey, MD, Professor and Chairman of Surgery, University of Kansas Medical Center, Kansas City; Emil J. Freireich, MD, Professor of Medicine and Chief of Research Hematology, M.D. Anderson Hospital and Tumor Institute at University of Texas in Houston; and faculty from McArdle Laboratory for Cancer Research and Division of Clinical Oncology at University of Wisconsin–Madison.

Further information: G. Ramirez, MD, 714-C University Hospitals, 1300 University Ave., Madison, Wis. 53706.

American Health Congress. The *quantity* of quality—how much quality exists in the health care system today—will be discussed by Joseph English, MD, president of the New York City Health and Hospitals Corporation, at the first annual American Health Congress.

Dr. English will address the subject: "Quality—Commitment or Compromise?" at the Congress, to be held August 7–10 at Chicago's McCormick Place. Expected to draw about 22,000 health professionals, the meeting is sponsored by the American Hospital Association, American Nursing Home As-

continued on next page

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin
Madison
1972

ON-CAMPUS CONFERENCES

July 22–23: *Ski Patrol Conference*

Aug. 28–Sept. 1: *Emergency Care Conference*

Oct. 20–21: *Podiatry Seminar*

Further information may be obtained from
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sociation, Catholic Hospital Association, and Health Industries Association.

The quality of care will be one of six topics discussed in afternoon-long programs. Following Dr. English's keynote address, ten concurrent sessions will be devoted to various aspects of the problem.

Ray Brown, executive vice president of the Northwestern University–McGaw Medical Center, will examine the chief executive's responsibility for quality and suggest how his competence can be measured. Involvement of medical staff in quality management will be explored by Thomas H. Ainsworth, Jr., MD, associate director of AHA.

A dialogue on whether teaching programs assure quality will also be featured. The session will explore such issues as whether the presence of house staff increases the quality of patient care and whether the cost of the teaching program provides proportionate benefits to the patient.

Among other subjects discussed will be quality as a patient right, and improved care through patient education. One session will focus on the use of computers in health care, both now and in the future.

Robert Cunningham, editor of *Modern Hospital*, will discuss "Delivery Systems —Real and Ideal," to keynote an afternoon-long discussion of health care delivery on Monday, August 7.

Present delivery systems will be examined in depth by Paul J. Sanazaro, MD, associate deputy administrator for development, Health Services and Mental Health Administration of HEW. The integration of government health services into a community health care system will be discussed by Marc J. Musser, MD, chief medical director of the Veterans Administration, and Edward Van Ness, executive director of the N.Y. State Health Planning Commission.

HMO's (health maintenance organizations) will be studied in detail through a case study approach. After a presentation on the development of one HMO, the audience will divide into three groups to discuss their own problems in setting up such a system.

Also on the agenda is a discussion of the physician's role in health care delivery to be presented by physicians from three sectors—a foundation, a group practice, and a fee-for-service solo practice.

Samuel J. Tibbitts, president of the Lutheran Hospital Society of Southern California, will discuss "Financing—An Overview of the Issues," Tuesday, August 8.

Following his presentation, ten cascading sessions will delve into specific issues within the area of health care financing. Included will be examinations of the relationship between quality and financial requirements, the implications of prospective vs. retrospective reimbursement, the search for long-term financing, the financial mechanisms of proposed delivery systems, and a unique approach to the department head's role in budgeting.

If the goals of management in a health care institution can be summarized in one word, it's "effectiveness," and the president of The American Management Association will explain how to achieve it. James L. Hayes will tell health care institution managers how to determine goals, motivate for effectiveness, and how to measure it when he keynotes an all-afternoon examination of "Effectiveness of Operation," Wednesday, August 9.

Following Hayes' presentation, he will be questioned by Morris Yoffe, president of American Medical Affiliates, Inc., and Addison Bennett, assistant executive director of the United Hospital Fund of New York. Nine presentation–discussion groups will then examine specific aspects of effectiveness of operation.

A display of drawings, photographs, and scale models of outstanding health care facility designs will be featured on the Congress exhibit floor. As many as 100 architectural firms are expected to exhibit examples of hospitals, long-term care facilities, health centers, diagnostic and treatment centers, medical laboratories, staff housing and medical research facilities which were completed after January 1, 1969 or are presently in the design or construction phase. A special section will be set aside for the display of nursing homes and other extended care facilities.

The exhibit is presented in cooperation with the American Institute of Architects.

Registration (free) for the American Health Congress is open to everyone having an involvement in health care. For forms, phone (312) 645–9417 or write to American Health Congress '72, 840 North Lake Shore Drive, Chicago, Ill. 60611.

American Academy of Orthopaedic Surgeons will sponsor a training course on emergency care and transportation of the sick and injured in Madison, August 28–September 1, at the Wisconsin Center.

Invited to attend the four-and-a-half day course of lectures and practice demonstrations are ambulance attendants, nurses, firemen, police officers, and others who work with persons requiring emergency attention.

The comprehensive training meeting will be held in cooperation with the University of Wisconsin Center for Health Sciences, and directing the course is Kenneth M. Sachtjen, MD, Madison orthopaedic surgeon.

Faculty members of the University of Wisconsin Center for Health Sciences and others will lead work practice sessions on the best ways of evaluating, treating, removing, and transporting the public in a wide variety of emergency medical situations.

Other groups cooperating in presenting the course are the Madison Police and Fire departments, Wisconsin State Patrol, American Red Cross, and the Dane County Traffic Department.

For information and registration forms, those interested may write to Mrs. Ann Johnston, Coordinator, Emergency Care Conference, Room 558, 610 Walnut Street, Madison, Wis. 53706.

American Association of Medical Clinics, North Central Region, will hold its annual session July 21 and 22 at the Holiday Inn, Urbana, Ill. The meeting will be hosted by the Carle Clinic Association, Urbana, and will commence with an afternoon registration period, Friday, July 21.

The two-day session will include panel discussions on: (1) computers in medicine, (2) physicians' assistants, and (3) clinics and medical education.

All interested physicians, clinic administrators, and observers are invited to attend. Additional information may be obtained by contacting John W. Pollard, MD, Carle Clinic Assn., 602 W. University Ave., Urbana, Ill. 61901.

American Association for Automotive Medicine, Sixteenth Annual Conference at the Carolina Inn, Chapel Hill, NC, October 18–21, 1972. Proposal of a paper for presentation is due April 15 to: John D. States, MD, Chairman AAAM Program Committee, 15 Prince St., Rochester, NY 14607. Areas of special interest with regard to medical aspects of traffic safety which may suggest a subject: (1) driver standards—licensing, (2) alcohol and drugs, (3) visual, (4) emergency medical services, (5) protective helmets and clothing, (6) restraint systems, active and passive, (7) motorcycles, (8) vehicle design, (9) medicolegal, and (10) data collection and analysis. INFO: James L. Weygandt, MD, President-elect, AAAM, 716 Monroe Street, Sheboygan Falls, Wis. 53085.

National Association of Underwater Instructors Course for Physicians in Diving Medicine, July 22–28, Princess Kaiulani Hotel, Honolulu, Hawaii. Primary objective of 7-day program, taught by physicians for physicians, is to acquaint the practicing physician with problems of underwater physiology and therapy for diving and diving related injuries.

Tentative class schedule includes: Review Diving Physics, Shallow Water Blackout and Effects of Cold, Basic Introduction to Diving, Pulmonary Physiology—Diving Related, O_2 Toxicity, Pathology of Underwater Accidents and Reporting, Barotrauma, Decompression Theory, Drowning, Problems with Inert Gases in Diving, Management of the Unconscious Diver, Decompression Sickness, Air Embolism, Diving Equipment, Management of Marine Animal Wounds, Physical Exams for Divers, Physical Fitness and Adaptation to Diving, Decompression Chamber Operation, Sham Treatment of Bends, Saturation Diving, and Sham Treatment of Diving Accidents.

Tuition: $200, covers Medical Program only. Special hotel accommodations provide either a double or single at $17 per day. Further info: NAUI Headquarters, Physicians Course, 22809 Barton Road, Grand Terrace (Colton), CA 92324.

Symposium on Health Finance Mechanisms, sponsored by Northeastern Wisconsin Health Planning Council at Beaumont Motor Hotel and University of Wisconsin–Green Bay in Green Bay, August 17–18. See details in GREEN SHEET.

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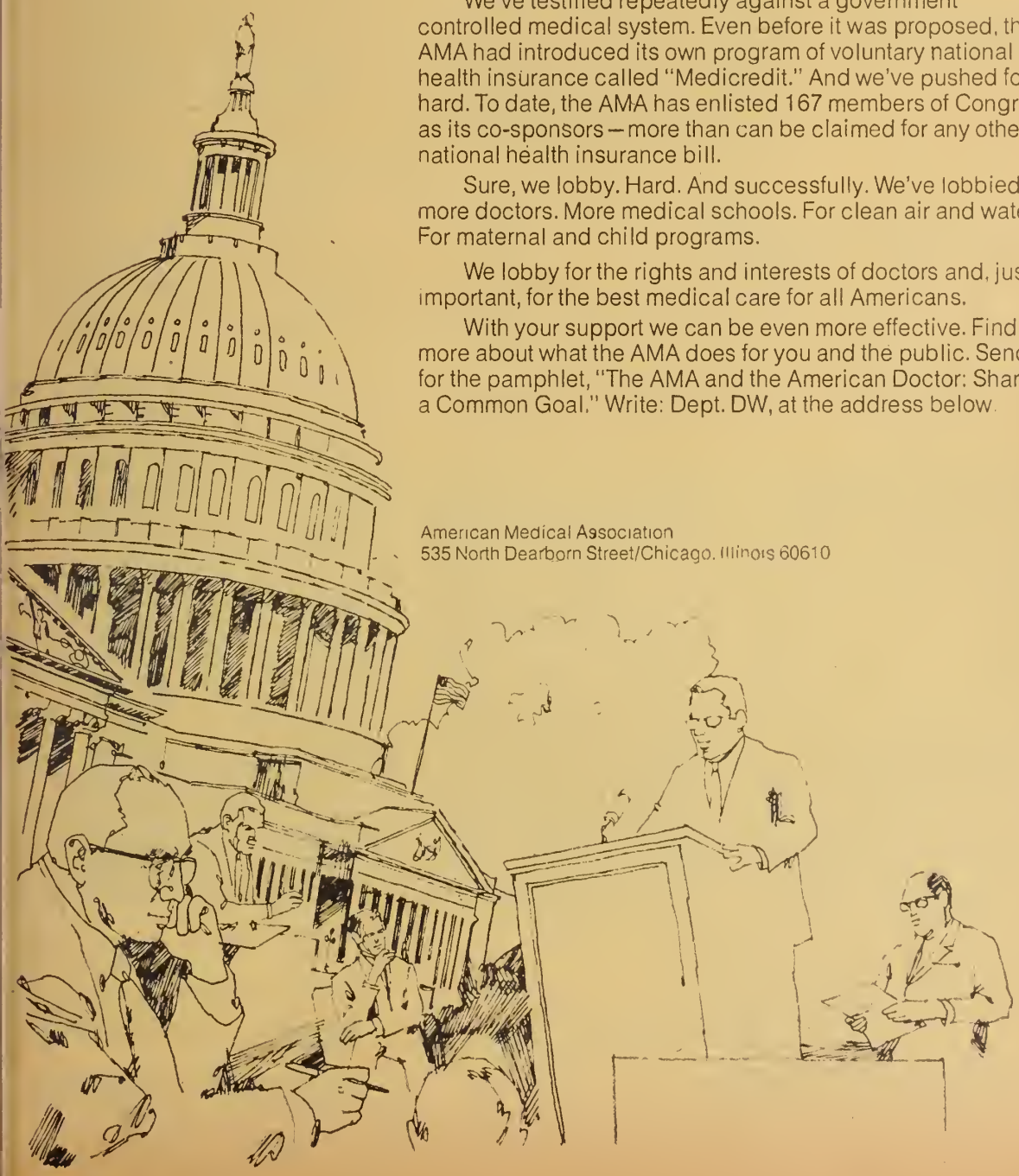
Sure, we lobby. Hard. And successfully. We've lobbied for more doctors. More medical schools. For clean air and water. For maternal and child programs.

We lobby for the rights and interests of doctors and, just as important, for the best medical care for all Americans.

With your support we can be even more effective. Find out more about what the AMA does for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

American Medical Association
535 North Dearborn Street/Chicago, Illinois 60610



CONTRIBUTIONS—CES FOUNDATION

April 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for April 1972:

Nonrestricted

NMC Projects Inc.	Contribution
Thomas H. Rees, MD	Contribution
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Memorial Account

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State Medical Society Members	Voluntary contributions of 28 MDs

Scientific Teaching—General

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W. D. Stovall, MD Memorial Account

State Medical Society Members	Voluntary contribution of 1 MD
American Association of Medical Assistants Inc.—Wisconsin Society, Dr. & Mrs. Fred J. Hodges, Charles E. Shearer, MD	Memorial: W. D. Stovall, MD

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorials: H. A. Sincock, MD, Ben S. McGiveran, Leo T. Crowley

Danforth Memorial Student Loan Fund

Mrs. Quincy Danforth	Contribution

W. W. & G. B. Hildebrand Memorial Account

W. B. Hildebrand, MD	Contribution
Capt. & Mrs. Joel Ford, Riverside Clinic	Memorial: G. B. Hildebrand, MD

Medical Student Summer Externship Program

Surgical Care Blue Shield	Contribution

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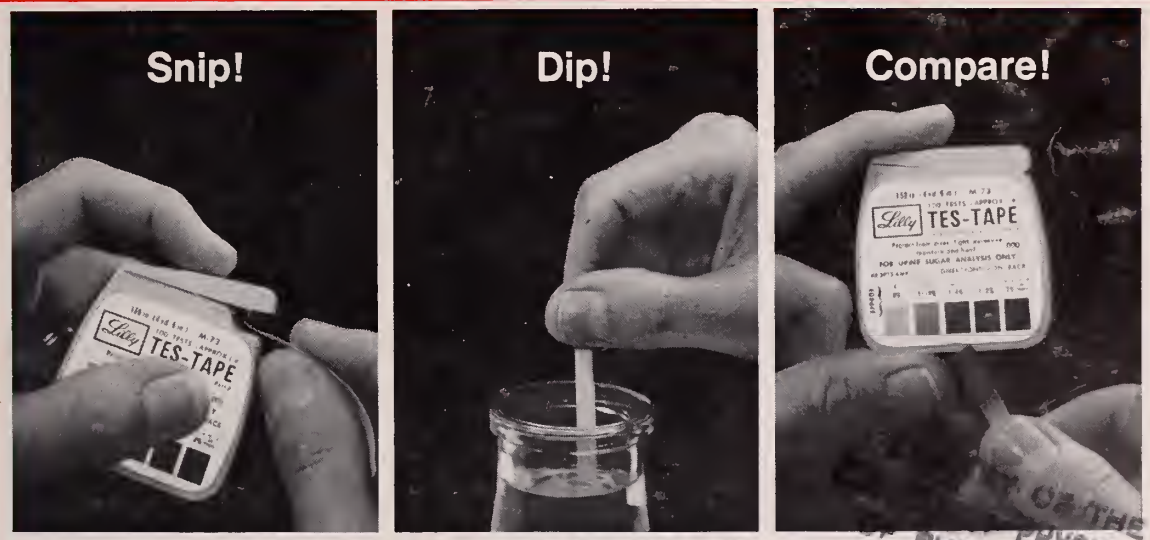
JULY 1972



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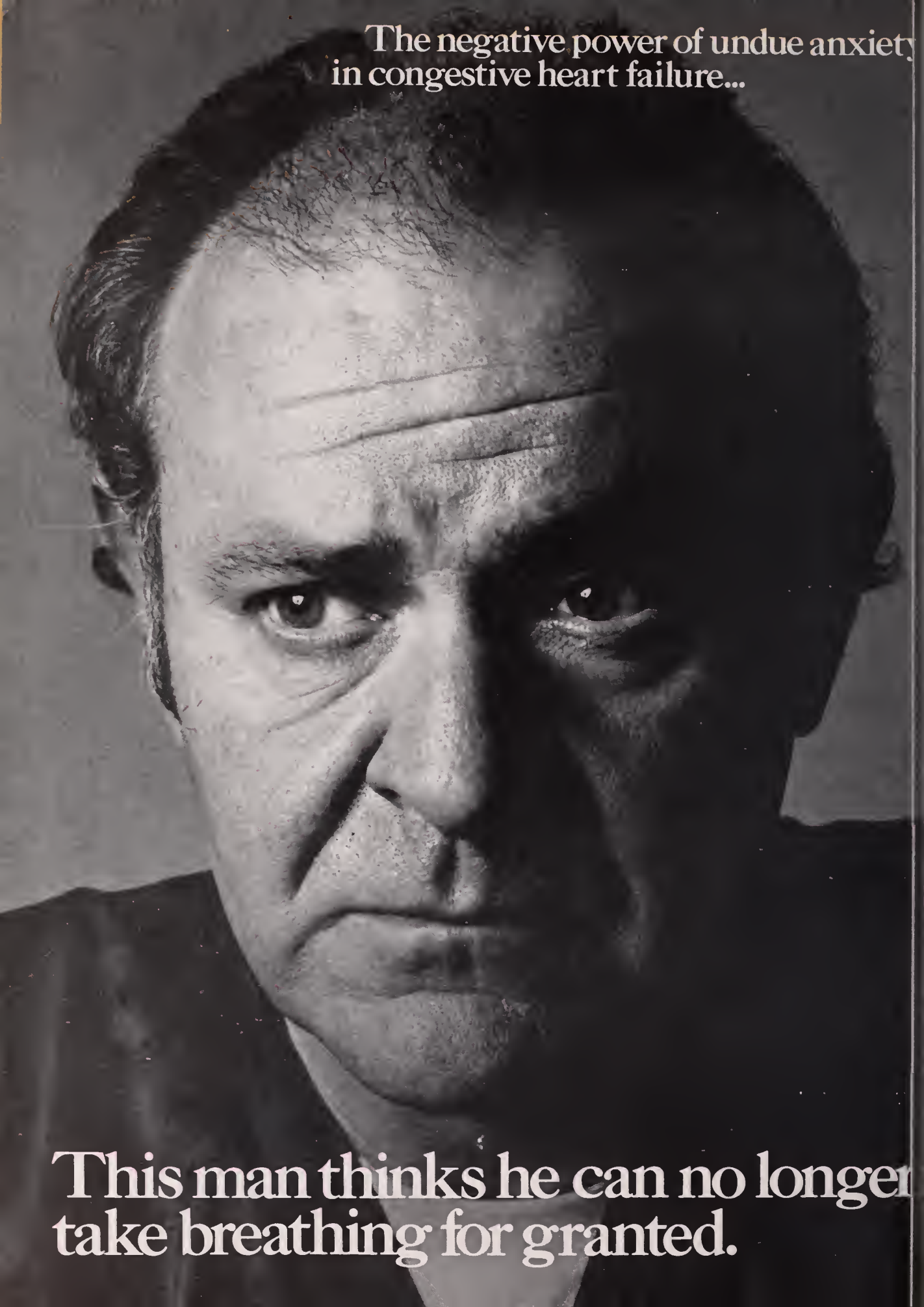
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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

PRESIDENT'S PAGE

Election Year—1972
March Toward Socialism

For these past many months, the American public has been bombarded with political rhetoric, wild schemes, and reforms of our way of life that would literally beggar the imagination. High on the agenda for reform is the Democratic health plank. The Democratic Platform Committee this month announced its decision regarding health.

The Committee leveled criticism at the inflation of health care costs and the decline of availability of health services. It also endorsed the principle that health care is a right for all Americans regardless of income or location. In another day a right was earned; saving and planning for misfortune was applauded.

The Platform Committee has proposed a federally financed—and administered—system of universal national health insurance which would cover all Americans with a comprehensive set of benefits including preventative medicine, mental and emotional disorders, and complete protection against catastrophic costs, and in which the rule of free choice for both provider and consumer would be protected. Thus the federal government would become the complete "Godfather" for all American health needs. There are many other provisions to the Democratic health plank relating to health maintenance organizations, added health manpower, provisions for greater consumer participation and control over health care institutions.

There may be some merit in parts of these health proposals as spelled out in the Democratic health plank. President Lyndon B. Johnson, using his self-announced "mandate," made federal funds available for free medical/hospital care for millions of Americans under the provisions of Title 18 and Title 19 of the Social Security Act. Since then the blame for the awesome cost of this legislation has been placed squarely at the foot of Medicine and the practicing physicians. Physicians became the whipping boys for a poorly planned, costly, giveaway program.

Physicians are deeply involved in the political plans that lay before us. We cannot be indifferent, disinterested, and unwilling to speak out on issues. I would urge each member of the State Medical Society of Wisconsin to become informed on these current issues confronting the American public. Your knowledge, your experience, and above all your opinion will be respected.

The political, educational arm of the State Medical Society has changed its name from Professional Association for Civic Education (PACE) to Wisconsin Political Action Committee (WISPAC). I urge you—each member—to mail your $25 membership check to WISPAC, P. O. Box 817, Madison, Wisconsin 53701. Please do it today.

Robert F. Purtell, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

A Necessary Distinction

WE HAVE ALL BEEN UNEASY at times when outsiders suggest we have not done our job well. Against medicine these suggestions can become overt and sometimes deliberately hostile. And yet if we stop to define just what our training has been, and what indeed our job today amounts to, much of the opposition could melt, or at least we could move out of the defensive stance.

If we allow that our training has been in anatomy and physiology and in the identification and treatment of disease processes, then no one can really say that medicine has failed. There may be individual complaints, a diagnosis missed, or some one kept waiting too long, but fundamentally we are given credit for success *as physicians.*

The rub comes when these reasonable expectations of doctors become extended into the broad social, political, and economic areas. In fact the general public as well as the responsive body politic has in the past twenty years made the same mistake that doctors have made, namely the assumption that we have training and competency in, for example, delivery systems, financing of medical care, and the like. It may be there are no experts in the problems raised by poverty or the confusions which arise when relatively simple information needs to be given to large masses of people. Economists and politicians, public relations people and communications experts, all have their special solution to offer to bring the bright white light of medicine to all the people. The more we read of all those proffered solutions, the more we may believe that our own personal solution is the best.

There really is no settled expertise in the areas for which we are being attacked, no matter how loudly or dogmatically someone proclaims. If physicians know this, and simultaneously know that they too have insufficient training and experience in methods of delivery of all sorts of care, in financing of community needs, and even in communications skills, then we can all start off even. We might even begin this way and work toward a solution rather than spending untold amounts of energy fighting and defending and being hurt and being aloof to those who do not "respect" us. It's possible that greater respect comes to those who know precisely what they can do and precisely what falls outside their realm of, e.g., medical expertise.

My most recent experience with this phenomenon was at a meeting of about ten persons, three of us

physicians. The three physicians were guests, the others were professional men and women in a community. The group had become concerned about the rising number of alcoholics in this particular community. Although we were invited, the content was clear, and even stated that physicians and psychiatrists had not been able to meet even a fraction of the needs of the community for treatment of alcoholics. Furthermore it was made clear to us that some in the group had spent many hours or years working with alcoholics and wanted to serve as advisors to physicians in this aspect of human distress and/or disease. An example of their concept of their own role follows. One person felt that their center should not limit themselves to alcoholics only, for example one person who came in was a child molester, had some problems with drinking, and "probably" had some psychiatric condition as well, in which case medical advice would be sought. Now this group may or may not be the wave of the future. Of course they could be wrong, for some of us believe alcohol is a chemical and like many other things can be misused, often with severe complications, e.g., tobacco, food, stimulants, and the like. The point to the editorial is not the somewhat mystic concept of the alcoholism but the need for both civic *and* medical groups to try and know what they can do and what they cannot. Physicians can become as expansive, as other mortals, and believe they have answers to communications bottlenecks, or full knowledge of one disease entity, or skill in full and total economic delivery. But we must stand equally firm against those lay groups who, although as well meaning in their expansiveness as physicians, can still be wrong. Perhaps we are coming into a battle of definitions, which may not be too different from the lines drawn in the dirt by the scruffy toes of ourselves as youngsters, defending our territorial rights. The results, however, now are much more serious, for us, for the consumer, and for the taxpayer.—RH

Personal and Professional

SOME MEN ACCOMPLISH outstandingly because they are geniuses, others because they work harder than most men. Armand Quick is a man who has both attributes. As a man of ideas, he enthusiastically continues to add to his long list of discoveries. Those of us who have known him for a long time can sense when another brilliant concept begins to form in his searching mind. Skeptics are always there to question and criticize him. Invariably, however, Quick emerges victorious months or years later. Few scientists have consistently worked so hard to win acceptance of the concepts which they confidently know to be correct.

Several years ago when he suspected that aspirin might affect hemostasis and spoke and wrote at length about why this is so, many hematologists either ignored him or were critical. If aspirin, the most commonly used drug, had this pharmacologic property, why hadn't it been observed before? Who knows how many important scientific discoveries have been aborted because they were not doggedly pursued by their originators! One can never say that Armand Quick left a good idea fall by the wayside.

During my years of association with Armand, first as a medical student and later as a faculty colleague, I knew him to be a man of principle and courage. He returned to Wisconsin in the 1930s to be close to his mother who had given up so much to sponsor his career as a graduate student in biochemistry and a physician. He joined the Department of Pharmacology at the Marquette University School of Medicine and filled in to teach a short course in clinical diagnosis to junior students. This was my first acquaintance with him. He had already described the hippuric acid test for liver function and had established the basic procedure for his prothrombin time determination. He enjoyed teaching, and he enjoyed teaching clinical diagnosis because he is a physician at heart. His tender loving care of the many hemophiliacs and others with hemorrhagic diseases who came to see him were always given the warmest personal attention. He had become Chairman of the Department of Biochemistry when I returned to the Medical School as Dean in 1947. His presence as a Department Chairman gave me confidence to accept that difficult job. He was a powerful force in bringing the Medical School to its present stature. He was concerned more for the medical implications of biochemistry than for biochemistry as a pure science, and this was reflected in his management of the Department of Biochemistry. Perhaps this is one reason why "pure biochemists" never fully accepted him. He, in turn, found great support and fraternity within the medical profession.

His latest challenge, which is described as the third hemostasis vitamin, will, I am sure, set the tongues wagging. I am willing to bet, however, that in a few years this concept will be accepted, and if it is, it will be due in no small measure to Armand Quick's diligence in promoting something that he confidently believes to be true.

When should a man retire? If he is a man like Armand Quick, never. Unfortunately this can be said of only a few of us.—JOHN S. HIRSCHBOECK, MD, Milwaukee. □

The American Doctor is under attack. What are we going to do about it?

You're concerned about the attacks. The AMA is just as concerned. But what are we doing about them? Some things we can't do. Some things we can do. And are doing.

We can't control the media. Its freedom is a constitutional guarantee. In one respect, newsmen are very much like doctors. They resent intrusions in their area of responsibility.

But the AMA is working hard to influence the media to follow a policy of greater fairness and objectivity in its reporting. Overcoming reporters' basic assumptions is a long term educational job. And the AMA is devoting more money and more manpower to it.

With some tangible results. The media is growing more aware that there is a doctor's side to every story, that solutions to national health problems are not easy. And we have succeeded in getting more doctors on public programs to express the profession's point of view.

Things won't change overnight. But the AMA is working on it. Hard. And we need your support. Find out more about what the AMA is doing for you and the public. Send for the pamphlet, "The AMA and the American Doctor: Sharing a Common Goal." Write: Dept. DW, at the address below.

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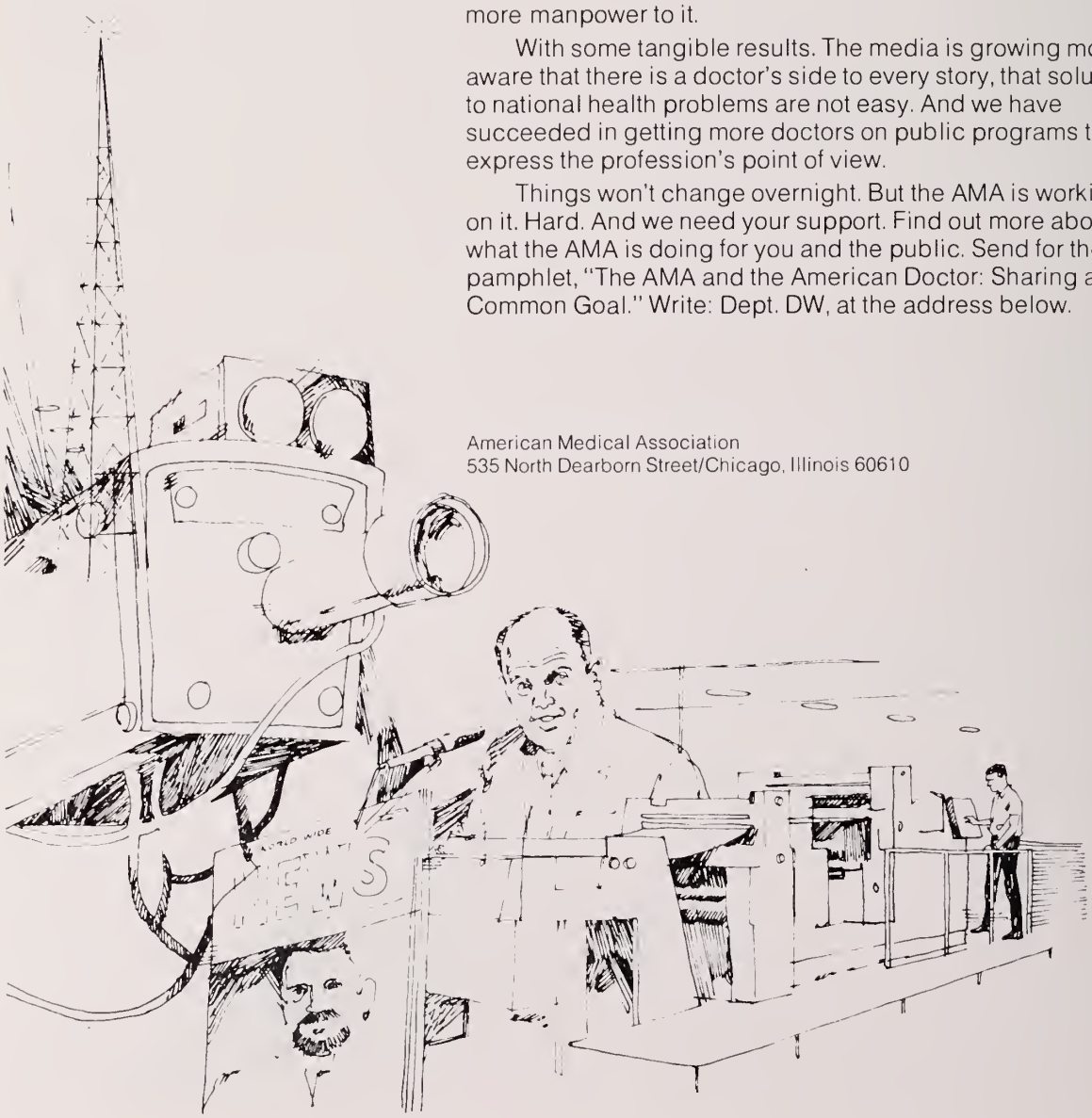

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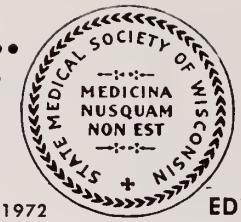

OPHTHALMOLOGY

July 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

READING DISABILITIES

On Jan. 25, 1972, the Milwaukee Ophthalmological Society sponsored a meeting at the War Memorial Center, on the lake front in Milwaukee, on the subject of "Reading Disabilities." We had as our main speaker, Delwyn T. Schubert, PhD, a professor of education at California State College in Los Angeles. Dr. Schubert also is director of the Reading Clinic at California State College, and received his education in Wisconsin, and his PhD at Northwestern University. He is well known by educators as an author and consultant on remedial reading, and has been a guest speaker on this subject on many occasions throughout the country. In addition a panel who answered questions after the main speech consisted of Paul Dyken, MD, Professor of Pediatric Neurology, Medical College of Wisconsin; Carl Reim, PhD, a full-time psychologist in the Department of Pediatrics at the Medical College of Wisconsin and Milwaukee Children's Hospital; June Dobbs, MD, Head of the Special Diagnostic Clinic for Abnormal Children, at Milwaukee Children's Hospital, and Otto Wiegmann, MD, Pediatric Ophthalmologist on the staff of Milwaukee Children's Hospital and Medical College of Wisconsin. Dr. Schubert also participated during the question period.

An attempt was made during the program to emphasize the multidisciplinary approach to reading problems, especially when these problems were not of a simple nature. We attempted to stress that there should be good communication between the school, the physician, and the parents, and that school systems should develop reading programs of a remedial nature for those who needed special help, so that these parents weren't forced to look outside of the school system for commercial reading care. We also were interested in establishing better public relations with the educational community; and consequently we sent out invitations primarily to educators in southeastern Wisconsin, and as far away as Green Bay and Madison. It was remarkable that there was an attendance of close to 300 people on a frigid evening, and that these people came from as far as Green Bay, the Fox River Valley, and Madison, to attend this meeting. At the door, prior to the meeting, the pamphlet called "The Eye and Learning Disabilities," which was a joint organizational statement put out from the American Association of Ophthalmology offices, was made available to all guests. This statement was prepared by an Ad Hoc Committee of the American Academy of Pediatrics, the American Academy of Ophthalmology and Otolaryngology, and the American Association of Ophthalmology, with the assistance of the President and the Past President of the Division for Children with Learning Disabilities of the Council for Exceptional Children. This pamphlet, as most of you know, also emphasized that there was no scientific evidence that treatment based solely on visual training, or neurological organizational training, was effective in curing reading disabilities.

In an attempt to get some feedback on the effectiveness of this meeting, I mailed a questionnaire to those who registered at the door and received 65 replies. There was an overwhelming agreement among those who replied that the program did emphasize the MDs interest in cooperating with the educator and emphasized the multiplicity of causes affecting the children, and the multidisciplinary approach necessary to this problem. It was also clear that most people felt it helped them to understand the role of the eyes better in reading disabilities, and that teachers should play the major role in handling this problem. In addition, most respondents felt that a need for future programs about reading disabilities, which might throw together medical doctors and educators, was a good idea. Many felt that small discussion groups with resource people available for each group would improve the program. Other comments by the respondents indicated that many felt a listing of services available, and resource people available to help with this problem was important. Others were of the opinion that the medical profession was not fully aware of present educational thinking regarding reading disabilities, and that we should be more open-minded about perceptual motor programs. Some thought that there should be a greater emphasis on remediation training methods.

In conclusion I feel that the program, which took a great deal of effort on the part of the Reading Disabilities Committee of the Milwaukee Ophthalmological Society, was worthwhile. It was very obvious that the subject is of considerable importance to educators in our community, and that they are eager to hear different viewpoints and gain more knowledge about it. I believe that this should be the beginning of efforts by ophthalmologists throughout the state to become more involved in such activities for the purpose of educating ourselves as well as the teaching profession; and to dispel the common opinion that we as ophthalmologists are not concerned about this problem, thus relinquishing the responsibility we have to our patients and community—HERBERT GILLER, MD, *Chairman,* Reading Disabilities Committee, Milwaukee Ophthalmological Society. □

WISCONSIN MEDICAL JOURNAL
Vol. 71, No. 7 JULY 1972

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Coming: Public Utility for Health Care?

Health care—a public utility like telephones, buses, and electricity? This is "where it's at" as far as Governor Lucey's Health Planning and Policy Task Force is concerned.

In May, Task Force Chairman David Carley started paving the way for a public utility concept of regulating health care. He began and ended the month with speeches to statewide gatherings, saying that the Task Force would propose the idea to the Governor. However, no such firm stand has yet been taken by the Task Force. The farthest in this direction the Task Force has gone so far is to adopt a resolution at its June 2 meeting which contains the outlines of the public utility concept.

The resolution states:

"We believe that the state government has the responsibility to exercise authority to act in behalf of the maintenance of the health of all its citizens.

"We believe that this State has the responsibility and the authority to provide means to fix accountability including but not limited to: cost control, rate review, licensure control and quality review of the components of the health delivery system.

"Be it resolved, that the Task Force and its staff explore the issues and alternatives involved in the regulation of health service functions, and prepare, as part of its final report, recommendations on regulatory functions related to health services delivery in Wisconsin."

The Task Force has been studying health care in the state, with a special eye to problems that might be remedied through legislation. By September 8, it is scheduled to have some proposals for public discussion. The final Task Force report with bills for consideration by the Legislature is due at the end of the year.

The idea of making health a public utility first received widespread publicity after a speech Mr. Carley made May 1 at the *Milwaukee Sentinel's* Forum for Progress. The theme of the meeting, "The Health Care Crisis," lent itself naturally to proposals for remedying the situation.

Mr. Carley termed the utility a "health care authority" which would:

*Control the placement and expansion of facilities as well as services provided.

*Review rates charged by institutions and providers.

*Set standards for licensure.

Rate increases, he said, would depend on evidence that the institutions and providers were functioning efficiently and that there was a need for additional services.

Mr. Carley hammered away at the idea May 31 in a 45-minute keynoted address to the Wisconsin Public Health Association annual meeting in Madison.

He said that "the consumer must be involved in establishing health policy. Some control must be given to the community, rather than reposing it entirely, and solely and exclusively in the professional within the health delivery scheme."

Mr. Carley said one of the problems is that "there is an evident lag in health legislation." Examples he gave of areas in need of legislative action were licensure (now "a one time stamp of approval in our state") and "control over placement and expansion of health care facilities and services provided within the facilities." He noted that in the last session of the Legislature "we failed to gain this kind of

continued on page 28

Dr. Hildebrand, Chairman of an AMA Council

William B. Hildebrand, MD, Menasha, has been elected chairman of the American Medical Association's Council on Medical Service. The nine-member Council is a standing committee of the AMA House of Delegates and its members are elected by the House. Its concerns are largely with socio-economics, health delivery systems and government programs.

Dr. Hildebrand

The Council has six standing committees on aging, community health care, government medical service, health care financing, health care of the poor, and private practice.

Coming: Public Utility for Health Care?

continued from page 27

control over health facilities. We hope that we don't fail in the next session."

He prefaced these remarks by saying "there is no question but that the resolution of the health problems of America will be found in the political arena."

The Task Force staff has distributed papers which discuss the public utility concept and its application to the health field. These papers have not yet been discussed in detail by the Task Force.

One of the background papers states that setting up a health care utility "appears reasonable and presents no great legal difficulties."

It describes utilities in general as "a unique mixture of private ownership, governmental control and dedication to the common good." It says they "have provided some of the best services in the country, at the lowest unit costs."

It describes this country's health system as having many of the earmarks of a monopoly.

"The individual consumer of health services must accept the quality level and price structure dictated by the provider-controlled system," the paper states.

The staff paper says "the health system is open to arbitrary action, exploitation and abuse by those who do control it."

The other staff report on the subject says that no state has a single governmental unit that controls licensing of health facilities, rate review, health planning, and combines governmental control with largely private health care providers.

It adds, however, that the states of Maryland, Arizona, and New Jersey come close to having such a governmental unit.

It appears that the health care utility as proposed for discussion would control the whole health care system. Both personnel and institutions would be included. All of this could be done by a single agency—one unit of government—although the Task Force has not yet decided this policy.

As it is now, there are health-related functions in several state departments. Many are contained within the Department of Health and Social Services, but work-related health matters fall under the Department of Industry, Labor and Human Relations. Licensing boards for physicians and nurses are part of the Department of Regulation and Licensing. A major reorganization would be required to separate health-related business from each of the state departments.

In his May 1 speech at the *Milwaukee Sentinel* Forum, Mr. Carley said "reorganization of state government in critical areas of health administration" would be inevitable to carry out the statement of principle made by the Task Force in February. That statement, as reported in the March GREEN SHEET, implied the use of public funds, laws, regulations and leadership "to assure acceptable service to all persons."

Under the proposed health care utility, licensing would be tied to a "health service mandate," commonly called certificate of need. This could result in the utility determining whether physicians, dentists, and pharmacists would have to practice in areas where there was not an oversupply of their profession or in areas of special shortages. For example, Madison or Milwaukee might be declared off limits for a particular specialty, such as surgery, if the public utility believed there were enough practicing there already.

Licensing would also be changed so that, according to Mr. Carley, it is not "a one-time stamp of approval." This, Mr. Carley said in his Milwaukee speech, "does not guarantee continual delivery of quality care." Presumably, the utility would periodically relicense providers in connection with a quality review.

The utility would be empowered to control charges made by physicians and other health care providers as well as those made by institutions such as hospitals and nursing homes.

Rate review by the utility would involve supervision of the premiums charged by insurance companies and such matters as insurance carrier "retention rates." A company's retention rate is the amount it keeps for reserves or profits after payment of claims and administrative expense.

Reactions of many of the physician members of the Task Force in an informal poll conducted by the State Medical Society was that discussion of a health care utility was premature now. Most felt Carley's comments that the utility concept would be a Task Force recommendation to the Governor were "trial balloons" aimed at stirring up discussion. This they have done.

Task Force member Paul R. Glunz, MD, a Beaver Dam pathologist, said that he had spoken to several physicians who were **"beside themselves"** with concern about the matter. He said his own feeling was that **"this is a new concept which is going to require considerable thought. If this means just another government regulation, I am not at all happy with the idea. My mind is wide open. I am willing to listen and review various alternatives. Hopefully, my fellow physicians will do the same and not act defensively."**

Another physician member of the Task Force, Robert McMahon, MD, a La Crosse internist, said he was afraid the type of health care utility described by Chairman Carley would mean the end of a physician's control over his own destiny. He said he felt **"we are better off with the mixture of public and private we have now."** He said he felt the airing of fee schedules in county medical society meetings as it is done now is a good method, but he acknowledged that perhaps consumers should have more of a voice than is presently the case.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Enormous Task Still Remains for TF Members

On June 1, 1971, Governor Patrick J. Lucey created a Health Planning and Policy Task Force. He charged this Task Force with the responsibility of developing a comprehensive health plan and policy for the State of Wisconsin.

In announcing its creation in May 1971 at a joint session of the Legislature, the Governor said, "I want this plan to be so excellent, so comprehensive and so outstanding that it can serve as a model for the nation."

The Task Force was instructed to:

. . . ascertain the health needs of Wisconsin citizens,

. . . design a comprehensive system which would provide the services health consumers require,

. . . compile a health plan and designate health priorities,

. . . recommend a legislative program,

. . . suggest any necessary administrative reorganization,

. . . identify the responsibility for government, the providers, the educational system and the consumers, and

. . . make recommendations on the financing of health care, utilizing both public and private capital, with a request for early identification of those areas demanding priority attention.

The Task Force was given 18 months in which to complete this far-reaching and significant undertaking.

It has now passed the one-year mark and is gearing itself for the remaining six months during which the Task Force will finalize a number of proposals (as reported elsewhere in this issue) and proceed with implementation of others.

The 40 citizens whom Governor Lucey chose to serve on the Task Force are listed below in alphabetical order following the chairman and vice-chairman:

David Carley (Chairman), Inland Steel Development Corporation, Madison

Ben R. Lawton, MD (Vice-chairman), Marshfield Clinic, Marshfield

Ray Alexander, Administrator, Mount Sinai Hospital, Milwaukee

James Anderson, PhD, Professor of Sociology and Anthropology, University of Wisconsin, La Crosse

William L. Blockstlin, PhD, Professor of Pharmacy and Chairman, Health Services Unit, University of Wisconsin Extension, Madison

Barbara Brown, Chairman, Department of Nursing, Alverno College, Milwaukee

Robert R. Cadmus, MD, Executive Director, Medical Center of Southeastern Wisconsin, Milwaukee

Robert Durkin, Vice-president, Milwaukee County Labor Council, AFL–CIO, Milwaukee

Peter L. Eichman, MD, Professor of Medicine and Neurology, and former Dean, University of Wisconsin, Madison

David B. Elesh, PhD, Assistant Professor of Sociology, University of Wisconsin, Madison

L. J. English, DDS, Arcadia

Marshall Erdman, Marshall Erdman and Associates, Inc., Madison

Walter Gleason, Executive Director, Walworth County Counseling Center, Elkhorn

Paul R. Glunz, MD, Beaver Dam

Stanley N. Graven, MD, Director, Wisconsin Newborn Center, St. Marys Hospital Medical Center, Madison

George H. Handy, MD, State Health Officer, Madison

Rick F. Heber, Director, Retardation Center, University of Wisconsin, Madison

Jean M. Helliesen, PhD, Associate Professor of Department of History, University of Wisconsin, La Crosse

Leonard W. Hickey, Hickey Real Estate Company, Inc., Beaver Dam

Inez Hinsvark, Dean, School of Nursing, University of Wisconsin, Milwaukee

John S. Hirschboeck, MD, Coordinator, Wisconsin Regional Medical Program, Milwaukee

Wendell Hunt, PhD, Department of Curriculum and Instruction, University of Wisconsin, Milwaukee

Winona G. Jackson, Day Care Services for Children, Milwaukee

D. C. Jacobus, The Jacobus Company, Milwaukee

Kenneth Jamron, Administrator, Deaconess Hospital, Milwaukee

Laflin C. Jones, Senior Vice-president, Northwestern Mutual Life Insurance Co., Milwaukee

John Kelly, President, Midland National Bank, Milwaukee

Gerald A. Kerrigan, MD, Dean, Medical College of Wisconsin, Milwaukee

John Martin, Assistant Director, Institute of Governmental Affairs, University of Wisconsin Extension, Madison

Stanley Matek, Executive Director, Mental Health Planning Committee, Milwaukee

Robert E. McMahon, MD, La Crosse

Norman Mitby, Director, Madison Area Technical College, Madison

Raymond C. Munts, PhD, Professor of Social Work, University of Wisconsin, Madison

Audrey Orlich, Citizens Group of Milwaukee, Milwaukee

John R. Petersen, MD, Director of Medical Services, Milwaukee County General Hospital, Milwaukee

Roberta Peterson, Administrative Assistant to a Pathologist, Eau Claire

Susan Kay Phillips, Ninth Ward Alderman, Madison

Dennis J. Purtell, Attorney, Porter, Purtell & Purcell, Milwaukee

John Rankin, MD, Professor of Preventive Medicine and Medicine, University of Wisconsin, Madison

Barbara Shade, Dane County Head Start, Madison

Gilda B. Shellow, Attorney, Shellow & Shellow, Milwaukee

Leo Suycott, President, Associated Hospital Services, Inc., Milwaukee

Earl Thayer, Secretary, State Medical Society of Wisconsin, Madison

Warren von Ehren, Executive Secretary, Wisconsin Hospital Association, Madison

Peter Weiss,, Psychologist, Madison

Coordinator of the Task Force is John Gregrich who has a staff of 14 persons. The Task Force offices are located in Room 714, One West Wilson Street, Madison, Wisconsin 53702. The office telephone number is 608/266–7550.

Society Council Meetings, Annual Meeting Dates Set

The next four meetings of the State Medical Society's Council have been scheduled for July 29, November 11, 1972, and February 10 and March 25, 1973. The 1973 Annual Meeting of the Society will start March 25, with a two-day scientific program on March 26 and 27. Hotel Pfister in Milwaukee has been designated as the site for all Annual Meeting functions.

State Agency Lobby Studied by Task Force

A proposal to permit state agencies a direct and continuing voice in the advocacy of health care legislation is being studied by the Task Force. The proposal originated within a Task Force subcommittee which seeks a change in present regulations prohibiting "lobbying" by the staffs of state administrative agencies. Task Force members acting as a whole rejected the first proposal and asked for further study.

Anticipated Products of Task Force Work Effort

Ambitious as it is, Governor Lucey's Task Force on Health Planning and Policy has recognized that it is composed of mere mortals. The Task Force staff has compiled a list of the projects it feels it can tackle between now and when it ends on December 31.

The staff has said that if there are additional matters for the Task Force to consider, the staff work will have to be done by the groups making the proposals.

Each of the nine Task Force work groups has projects underway. A brief rundown of the projects scheduled for completion is as follows, listed by work groups.

Health Services Research and Development

This work group has received tentative approval from the National Institutes of Health (NIH) for a research project on ambulatory care. It plans to study phycians' offices, group practices, and emergency rooms to see what kinds of care are given in these places. It also wants to see what sorts of patients (age, location, diseases) receive care here.

Additionally, the study proposes a "dynamic manpower inventory" of health care personnel. This will be an attempt to find out who the professionals are who are coming to the state, where they locate, what they do here, and why they leave.

An NIH site visit for this grant took place in Madison June 16. The Task Force application was tentatively approved for $250,000 for a two-year period, less than requested.

Initial cooperation and support has been pledged by the University of Wisconsin Family Practice Program and the University's Family Health Service. The work group noted that the Marshfield Clinic also may take part in the study and that others could be brought in at a later time.

The Work Group on Health Services Research and Development also is composing discussion papers on development and use of new health delivery techniques, ways to test them, and ways to implement them.

Health Financing

There is a need to regulate health insurance policies' content and sale in the state according to a Task Force statement of February 25. The Health Financing Work Group is now holding meetings with the State Insurance Commissioner to develop specific recommendations in these areas. The recommendations will be forwarded to the Legislature, the Insurance Commissioner and Governor Lucey's Health Policy and Program Council.

The State Medical Society's proposals on financing health care for the unemployed and the uninsurable in Wisconsin (as reported in the March GREEN SHEET) will be considered by this group for implementation. One possible approach being discussed is a "citizens' group health plan" for those who do not qualify for group health insurance, such as the unemployed, or those not eligible for group insurance through other means.

This work group also is exploring state spending for health and health-related areas, such as mental health services and the education of health workers. Discussion about mental health services, for example, has centered around changing the approach from centralized state hospitals to local community centers for such care. Specific proposals are expected to be made by other Task Force work groups.

Education of Health Workers

This work group's proposal for establishing Area Health Education Centers (AHEC) in the state has been approved by the Task Force as a whole and is described elsewhere in this month's GREEN SHEET.

Other reports being prepared by the Work Group on Education of Health Workers will detail the costs of health education programs in the state, outline difficulties in nurse training, identify who is responsible for the state's health education policy, and suggest alterations in the licensing system. One alteration of licensing may be to require periodic relicensure, giving licensing agencies quality control powers.

An additional proposal by this work group is for study of ambulatory care under a National Institutes of Health grant, an identical suggestion to that made by the Work Group on Health Services Research and Development, described above.

The Task Force as a whole has already supported in principle the State Medical Society's recommendations to expand the state's medical schools, develop additional residency programs, and improve continuing and postgraduate medical education. Both medical schools are awaiting federal funding to aid their expansion plans and both tentatively support development of residency programs in the state outside of Madison and Milwaukee.

Transportation

This group was established when the Task Force found that Wisconsin citizens feel improving transportation to health services is necessary to improve care. The Task Force Work Group on Transportation is outlining what emergency medical services the state should have and what legislation is necessary to get them.

In cooperation with the Task Force, the Wisconsin Regional Medical Program (WRMP) has proposed a statewide emergency medical service (EMS) system. WRMP planned the system with the help of several state government departments, both Wisconsin medical schools, the State and Milwaukee County medical societies, and many other agencies and services.

WRMP is awaiting word from the U. S. Department of Health, Education and Welfare on whether the proposal will be funded. The grant request is for nearly $2 million, the largest request for funds by a Regional Medical Program since the RMPs began in 1966. If the money does not come from Washington, the Task Force will help search for other ways to pay for the project.

(The Wisconsin Regional Medical Program is announcing in TRENDS, which appears else-

where in this issue, the awarding of the grant and details concerning its use.)

The money would pay for a three-year plan to organize statewide communications and transportation for emergency medical care, to train personnel, and to buy equipment. Some of the major things that would be done are:

* Establish a statewide microwave communication system linking emergency vehicles, hospitals, police dispatchers, and other emergency agencies throughout the state.
* Integrate existing training programs for ambulance attendants into the statewide emergency service program.
* Develop specialized training programs for specific types of emergency care such as heart attacks, severe bleeding, and life-threatening injuries to the chest and head.
* Provide 100 ambulances with specialized communication systems through the state's highway safety program.
* Train medical personnel in hospital emergency rooms.
* Improve urban hospital emergency departments by establishing ambulatory emergency sites for "non-emergency care," the type of care that now takes up to 70% of the time and resources at present departments.

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STATEMENT OF PRINCIPLE

ADOPTED BY THE

Governor's Health Planning and Policy Task Force

FEBRUARY 25, 1972

We have reaffirmed our position that health *services* are essential to well being; therefore, it is a proper concern of public policy that health services be equitably available to all.

THE ACTUAL HEALTH SERVICES WHICH ARE REQUIRED (TO OVERCOME, AMELIORATE OR PREVENT ILLNESS AND HEALTH PROBLEMS) FOR A *DEFINED POPULATION* PROVIDE *THE PROPER BASIS* FOR PUBLIC POLICY AND PLANNING FOR HEALTH.

More specifically:

- The requirements for health workers, programs and facilities are properly *determined by* and derived from requirements for *services.*
- The entities and organizations which make up the health system must be held *responsible for* and *accountable to* defined populations. Collectively they must serve the entire population.
- The *financing* of health services, insuring against the economic cost of illness, and the *education* of the public are *service functions* and are publicly accountable. They must serve everyone, and the financing and distribution of service must be equitable.
- Policy and planning bodies at the state, regional and local levels must be held responsible for and accountable to the populations they serve.
- The missions of health profession education and of research are properly assigned to capable, responsible institutions as part of public policy. They are not developed by the institutions alone.

General Implications:

- *Access* to an acceptable range of health services will be *guaranteed* for all.
- Public funds, laws, regulations and leadership will be used to *overcome inequity* in the availability of health services, and to *assure acceptable service* to all persons.
- The establishment of policy and planning based on the *service needs* of users implies *limitation of freedom* for both providers (practice location, specialization, institutional planning) and users ("a doctor in every town").
- A focus on *service needs* encourages *alternative means* to provide the service (assistants, satellite clinics) and *reorients* traditional *responsibilities,* roles and models of organization.
- The person-to-person relationships between health workers and patients is a desirable characteristic to be preserved but must be supplemented by *formal relationships* between service organizations (or systems) and the defined population for which and to which the organization is responsible (the organization could be individual practitioners, groups, county societies and hospital staffs, etc.)
- Effective planning requires that means be developed to *measure (and predict) the service requirements* of the population. Adequate and ongoing collection and analysis of information are thus essential and require substantial investment and direction.
- Licensure, certification and supervision and monitoring of practices (of direct health service, of financing practices and education) will face needed *alteration to maximize* service *benefits* while seeking efficient and less costly approaches.

Anticipated Products of Task Force Work Effort

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* Categorize all Wisconsin hospitals in terms of their ability to provide specific levels of care.

As envisioned in the WRMP proposal, the EMS will be controlled at the top level by a 46-member EMS Task Force. This will be made up of representatives of the various hospitals, schools, governmental units, and planning agencies involved in the service, and five consumers. Under the EMS Task Force will be eight regionalized councils, one to each area served by the eight areawide health planning agencies.

Health Planning

New state laws are needed to define the tasks of Wisconsin's state and regional health planning agencies, according to a position taken by the Task Force on February 25. The Task Force noted that the state's health planning agencies have been set up by the federal government and their existence depends upon continued federal support. Should money for these agencies suddenly be cut off by the federal government, no provision exists for the state to go ahead with similar activities.

The Work Group on Health Planning has prepared a guide to how Wisconsin health planning should be organized. From this specific proposals are being developed for public discussion and eventual legislation.

The work group's guide contains many recommendations that mesh with the idea of making health care a public utility. (See article on public utility concept elsewhere in this month's GREEN SHEET.) Particularly, the guide states that policy on health matters should only be made based on the recommendations of health planning groups at the local, area, and state levels. Those who set health policy in any other way "should place on record the grounds for their decisions." The guide says that health planning groups should be consulted on all health policy decisions within the state which are made by public organizations as well as by private organizations acting with public funds.

The guide says Wisconsin's health planning areas should "conform as closely as feasible to the state administrative districts." It proposes that impetus to set up these areas come from the Health Policy and Program Council, which was established at the same time as the Task Force. The Council will be taking over many of the Task Force functions when the Task Force ends December 31.

Environmental Health

This work group is preparing reports on the key relationships of environment and health. It is considering those factors that affect health other than the health care industry, such as air and water pollution, housing, and food contamination. The group has noted that coordination is needed between state and local governments to control environmental problems. Final recommendations will be made for further work by other agencies, including the Health Policy and Program Council.

Health Education of the Public

Use of the schools for health services both to students and the public has been proposed by this work group (see article elsewhere in this month's GREEN SHEET). Specific proposals will be made for legislation as well as recommendations to the State Department of Public Instruction and Department of Health and Social Services.

The Work Group on Health Education of the Public also plans to make specific proposals about the statewide organization of public health education.

Personal Health Services

The state's stop order on construction of county mental hospitals announced early in June was the result of Task Force recommendations. It was based on the critical view being taken by the Task Force and Governor Lucey of inpatient care for mental patients.

Governor Lucey said in a speech in May that "the Health Task Force has reinforced and elaborated the need to redirect priority for public funds from support of the more expensive primarily long-term residential institutions to community-based and ambulatory services."

This subject, along with such related problems as alcoholism and drug abuse, has been found of such importance by the Task Force that the Personal Health Services Work Group has set up a subcommittee on developmental, behavioral, and chronic problem.

The stop order is a temporary action, awaiting a proposal on inpatient mental health care which is being drafted by the subcommittee. This will look at the future role of county and state mental hospitals. The subcommittee is also preparing proposals on outpatient mental health care and alternatives to institutionalization, expansion of treatment for alcoholism and other drug abuse, and changes in health insurance coverage of mental illness, alcoholism, and drug abuse.

Other proposals may be forthcoming on the elderly, children's mental health care, and the health system's relationship to developmental disabilities, such as mental retardation.

The Personal Health Services Work Group is making proposals involving the peer review corporation, Wisconsin Health Care Review, Inc. (WHCRI), set up last December by the State Medical Society, the Wisconsin State Dental Society, and the Wisconsin Hospital Association.

Other projects are being planned with other Task Force work groups and are described elsewhere in this month's GREEN SHEET. These include minimum standards for health insurance (with the Finance Work Group), Area Health Education Centers (AHEC) and the manpower production study (with the Education of Health Workers Work Group), health services for school children (with the Health Education of the Public Work Group), and the public utility for health care (with the Public Policy Work Group).

An additional project of the Personal Health Services Work Group is making recognition of the need to better serve groups with special health needs.

(An article on AHEC appears on page 35 of this issue following the GREEN SHEET.)

Evaluation of Health Services

This work group is going to ask that health delivery programs be evaluated on a continuing basis, starting with those supported by the state. The group would like to look at all of health delivery, but has chosen the state-supported services simply because it is the easiest place to start.

Legislation in Process

Legislation on health requested by Governor Lucey will be reviewed by the Task Force. The Task Force will propose specific modifications of that legislation. Bills which the Task Force may endorse include:

* Employment of physicians on a salaried basis.
* Permission for Medicaid (Title 19) recipients to participate in prepaid group care.
* Treatment of venereal disease in minors without parental consent.
* Creation of a state forgiveness loan program for medical students.
* Certificate of need.
* Drug prescription by generic name.
* Physician assistants.
* Revision of licensure legislation.

Chiropractic

The Ad Hoc Chiropractic Study Group is meeting with several groups, including physicians and chiropractors. No specific proposals have yet been developed. The committee will present a final report by September 1, to include findings, conclusions, and proposals.

Members of the group are: Attorney Gilda B. Shellow, Milwaukee, chairman; Prof. William Blockstein, chairman of the University of Wisconsin Extension Health Services Unit; Robert Durkin, vice-president of the Milwaukee County Labor Council, AFL–CIO; and Prof. Wendell Hunt, University of Wisconsin—Milwaukee Department of Curriculum and Instruction.

Health Policy

Projects in this area include a proposal to better define between state and local government where responsibility lies for direct health services as well as technical assistance. Also underway is a proposal to identify what health information is required for state policy development as well as for multi-county and local organizations.

The work begun by the Task Force in this area is expected to be carried on after the end of the Task Force life in December by the Health Policy and Program Council headed by Ben Lawton, MD, Marshfield. The Council was set up by Governor Lucey at the same time as the Task Force. Its original duty was to act as an advisory board to five state health agencies which have federal funding: comprehensive health planning, developmental disabilities, hospital construction, mental health centers construction, and facilities for the mentally retarded. Work is underway now to define exactly what the Council's future responsibilities should be and how it should be structured for its new role.

Regulatory Functions

Work in this area basically concerns the public utility for health care reported elsewhere in this month's GREEN SHEET. If and when the utility becomes a reality, a way of administering it through the state government would have to be developed. This would mean creating one or more new state agencies or giving the authority to bureaus already in existence.

Schools May Provide Initial Entry to Health Services

Part of having a good health care system is being able to find those who need help and making that help easily available.

Using the schools to reach everyone in the community is the approach that has been suggested by the Work Group on Health Education of the Public of Governor Lucey's Task Force on Health Planning and Policy. The work group proposed the idea in its recent progress report, "The Role of the Schools in Providing Health Services." Copies of the report have been given to all Task Force members, comprehensive health planning agencies, and 15 other groups for discussion. The work group is one of nine Task Force groups studying major health areas.

The schools offer "a unique opportunity" for reaching both children and adults with health screening and care, according to the reports. This is because most people go through the school system and also because the school is in the center of the community and thus convenient to almost everyone.

"Not every town has a hospital," the report says, "but nearly every town has a school." It proposes using school facilities in a better way where children are concerned and also giving the school a role to play in adult health care and education.

Many schools already give their children some health services, but the report found some gaps in that service, including:

* Ineffective followup of the screening programs that do exist;
* Inaccessibility of a child's health record to school staff;
* Labeling as "emotionally disturbed," "hard of hearing," "speech defective," etc. those children that the schools help.

Health care should be considered an important school concern the report notes. "What seem desirable," it says, "is that the schools take on the whole person rather than creating a mind–body dichotomy by addressing themselves only to the mind. The physiological basis for behavior, performance and achievement should not be ignored."

The schools might even be used to give tests and shots to the whole community, the report suggests, "possibly using the school system health staff as well as its buildings and buses." This was suggested as particularly valuable for isolated areas such as

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Schools to Provide Initial Entry to Health Services

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rural communities and urban ghettos.

A major obstacle to the idea is money. Schools are chronically short of funds these days, so funds from local sources probably wouldn't work. This means that the kind of program the work group suggests would have to compete for state money with many other types of health services.

Members of the Health Education work group have suggested that four steps be taken toward establishing the school health program it outlined:

(1) Clear up laws on health care in schools so that the same services can be available throughout the state.

(2) Keep records in all schools in the same way, so that the information can be used by school districts, district coordinators, and state officials alike.

(3) Start a pilot program to devise ways of effectively screening and following up the problems uncovered.

(4) Make preschool health and learning a legitimate school concern.

The paper and its recommendations will be considered at future meetings of the Work Group on Health Education of the Public. Final recommendations of the group will be used by the Task Force in making recommendations to the Governor, the Legislature, the Department of Health and Social Services, and the Department of Public Instruction.

MDs Appointed to WRMP

Three MDs recently were appointed to the Board of Directors of Wisconsin Regional Medical Program (WRMP). Dr. Henry C. Pitot, Acting Dean, UW Medical School, Madison was elected for the first time. Dr. Gerald A. Kerrigan, Dean, Medical College of Wisconsin, Milwaukee, and Dr. Jerry W. McRoberts, Past President, State Medical Society of Wisconsin, Sheboygan, were reelected.

Dr. Ben Lawton Heads Society-Task Force Liaison Committee

Ben R. Lawton, MD, Marshfield, vice-chairman of Governor Lucey's Task Force on Health Planning and Policy and chairman of the Health Policy and Program Council, has been named chairman of a liaison committee to meet with the State Medical Society of Wisconsin. The object of the liaison committee is to increase understanding between the State Medical Society and the Task Force.

Warren von Ehren, executive secretary of the Wisconsin Hospital Association (WHA), will serve as chairman of a liaison committee between the Task Force and WHA. He is a member of both the Task Force and the Health Policy and Program Council.

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What Is AHEC? Area Health Education Center

AHEC is not a new way of expressing disgust. It is the acronym for a new approach to health education.

AHEC stands for Area Health Education Center, an idea which was adopted for further study by Governor Lucey's Task Force on Health Planning and Policy at its meeting June 2.

The term is not a new one. In fact, the idea received quite a bit of attention in October 1970 when it was among the recommendations of the report, "Higher Education and the Nation's Health," issued by the Carnegie Commission on Higher Education.

The Carnegie Commission suggested that 126 AHECs be developed across the nation. Eight AHECs of one type or another are already in existence, funded by the Veterans Administration. Now it is possible that such an approach may become a reality in Wisconsin.

At its June 2 meeting Task Force members adopted a proposal which sets forth the idea along with steps necessary for establishing a pilot program.

AHEC is an effort to coordinate an area's health education. It would take in all of a region's schools and hospitals—both public and private—along with the area's health planners. In turn, the AHEC would work with some central coordinator or to make sure that region's efforts mesh with the needs and programs of the rest of the state.

All of the institutions would participate in AHEC on an equal basis. However, depending upon the program involved, some would be more equal than others. For example, in the case of medical student and residency programs, the two medical schools would necessarily have more input than the vocational schools or local colleges. In other education programs, others would have a louder voice, depending upon their involvement. The cooperation and coordination made possible by an AHEC would allow several kinds of students to use the same facilities and the same faculty.

The incentive for all of the schools to cooperate in AHEC would be government money: those who didn't cooperate might be financially left out in the cold. With today's tight finances in education generally, virtually all schools are dependent upon some government support.

As spelled out by the Carnegie Commission, an AHEC would provide facilities for patient care, for educational programs of house officers and rotating medical students, clinical experience for allied health students, and continuing education programs for all types of health manpower.

In the past year the Regional Medical Program (RMP) has developed further the Carnegie Commission's AHEC idea. It sees the AHEC program as health care providers and educators working together to give both service and education, including public health education. They in turn would work with health planners to determine what the community's manpower needs are. The RMP recommends setting up an AHEC as a not-for-profit corporation with both consumers and providers represented on the board.

RMP papers outlining AHEC for Wisconsin note that five systems in the state already provide the potential for coordination of health education and service:

(1) Several types of planning groups including the eight comprehensive health planning agencies getting underway across the state, Governor Lucey's Health Planning and Policy Task Force, and the Governor's longer-term Health Policy and Planning Council. The Council will probably continue much of the work the Task Force has begun after the Task Force goes out of business at the end of the year.

(2) The merged University of Wisconsin system, which offers the potential for coordinating health education programs in all of the state universities.

(3) Wisconsin's vocational and technical educational system which aims programs at local needs while being coordinated by a state level organization.

(4) The relatively new University of Wisconsin Health Sciences Center, which can encourage active relationships between the university and all health professionals and organizations within the state.

(5) The developing Medical Center of Southeastern Wisconsin, which seeks to coordinate the health educational resources of the Milwaukee County area.

Membership of an AHEC, as outlined by the Task Force staff paper, would include no direct representation of physician organizations or the organizations of other health care providers. Consumers, government, educational and service institutions are heavily represented, however, including hospitals and the district branch of the Wisconsin Hospital Association.

The Task Force has suggested that Wisconsin develop a statewide network of AHECs. None of them would be larger than a state administrative district. To do this, a state policy is needed which affirms the state's commitment to the coordination of health education and health service.

Now that the Task Force has decided on the AHEC idea, the Task Force staff is at work putting the nuts and bolts together. One promising source of money to set up a model AHEC is a $19 million chunk which came out of Congress last April. Since then, some bureaucratic shuffling has been going on within the U.S. Department of Health, Education and Welfare (HEW) over who will be administering the funds. It now looks as though HEW's Bureau of Health Manpower has control. That bureau is getting

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At a Stovall memorial ceremony April 30 at the Museum of Medical Progress in Prairie du Chien, a striking colored photograph of Dr. William D. Stovall set along side a bronze engraved plaque mounted on a walnut base was unveiled before a group of his close friends, colleagues, relatives, and admirers. Shown here are (left to right): E. M. Dessloch, MD, Prairie du Chien; Mrs. Janice Stovall, Dr. Stovall's daughter-in-law, and his granddaughter, Victoria Stovall, both of Madison; and Robert T. Cooney, MD of Portage.

Stovall Memorial Plaque Unveiled

"The health of the community is the aggregate of the health of the individual. To know about the community you have to know all about the individual."

This was the philosophy of Dr. William Stovall, Madison, and one that made him one of the finest pathologists this country produced, according to H. Kent Tenney, MD of Madison, speaking at a Stovall memorial ceremony April 30 at the Museum of Medical Progress in Prairie du Chien.

Doctor Stovall believed that modern laboratory tests are a necessity in knowing about the individual, and on this basis made the Wisconsin Laboratory of Hygiene a national leader, Doctor Tenney said. Doctor Stovall was director of the State Hygiene Laboratory from 1915 to 1958 and served on the University of Wisconsin faculty from 1914 until his death.

At the memorial ceremony a plaque commemorating Doctor Stovall's many contributions to the state was placed in Prairie du Chien's Museum of Medical Progress. When Doctor Stovall died at the age of 84 last November, he was president emeritus of the State Medical Society of Wisconsin's Charitable, Educational and Scientific Foundation which operates the Museum.

Others speaking at the ceremony included A. W. Winter, Mayor of Prairie du Chien, and Robert T. Cooney, MD, Portage, president of the CES Foundation.

What Is AHEC? Area Health Education Center

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ready to send out guidelines to those interested in applying for the money. Needless to say, the health task force is on that mailing list.

Some ideas on AHEC may be coming soon from the University of Wisconsin. A Special University Committee on Allied Health Professions Education has been meeting with non-University allied health educators. It is headed by William Blockstein, PhD, a member of the Task Force. Professor Blockstein says recommendations concerning AHEC were a part of the committee's recommendations in a report to University President Weaver. The committee hopes to know soon what sort of action will be taken on its recommendations.

Continues on WRMP Board

J. W. McRoberts, MD, Sheboygan, was selected by the State Medical Society's Council at its May meeting to again represent the Society for a one-year term on the board of the Wisconsin Regional Medical Program (WRMP). Dr. McRoberts also served on the board during the past year.

"fotos/72" Prize Entries Named

Two innovative uses of the camera and the enlarger topped the entries in **fotos/72,** the State Medical Society's annual photography contest. The exhibit was held at the Marc Plaza (Sheraton–Schroeder Hotel), Milwaukee, in conjunction with the 131st Annual Meeting of the State Medical Society, May 8–11.

Best in Show—Color was an eerie creation entitled "Dream of a Witch's Sabbath" by Dr. Anthony V. Pisciotta, Milwaukee, which also took first place in the class, people.

Best in Show—Black and White was a photo-montage, "Rolling Stone" by Dr. John Bunke, Waukesha, which also placed first in the pictorial category.

Other prize-winning entries were:

Travel: First place—"Business is Slow" by Dr. Anthony V. Pisciotta, Milwaukee; second—"Fishing, Chinese Style" by Dr. Joseph L. Teresi, Brookfield; third—"China Town, San Francisco" by Dr. John Erbes, Milwaukee; honorable mention—"Devils Island, San Francisco Bay" by Dr. John Erbes, Milwaukee.

People: First place—"Dream of a Witch's Sabbath" by Dr. Anthony V. Pisciotta, Milwaukee; second—untitled by Dr. Marvin J. Roesler, Delavan; third—"I'm Certainly Glad that Cows Can't Fly" and "What's So Scary about Flying?" by Dr. John Erbes, Milwaukee; honorable mention—untitled by Dr. Raymond L. Rice, Milwaukee.

Medicine: First place—"Urate Crystals As Seen Through A Microscope Using A Mineral-Analyzer, from A Gouty Tophus (Magnified Approximately 900,000x)" by Dr. Edwin L. Bemis, Milwaukee; second—"Professor of Anesthesiology" by Dr. John Erbes, Milwaukee; third—"Ruptured Gouty Tophus" by Dr. N. A. Eidsmoe, Rice Lake.

Animals: First place—"Will Somebody Please Call A Plumber" by Dr. John Erbes, Milwaukee; second—untitled by Dr. E. R. Jonas, Ellsworth; third—"Nobody's Home" by Dr. Anthony V. Pisciotta, Milwaukee; honorable mention—"So—I Drink A Little" by Dr. John Erbes, Milwaukee.

Pictorial: First place—"Rolling Stone" by Dr. John Bunke, Waukesha; second—"Sunset" by Dr. Anthony V. Pisciotta, Milwaukee; third—"Nor'Easter" by Dr. John Bunke, Waukesha; honorable mentions—"Fishes, Fishes, Fishes!" by Dr. Joseph L. Teresi, Milwaukee, "Ye Olde Yard Arm" by Dr. Teresi, and "Stonington Harbor" by Dr. John Bunke, Waukesha.

Driver's License Can Identify Organ Donor

An automobile accident on a Wisconsin road. Someone is killed. When the police officer at the scene checks for identification, he sees a small green sticker on the driver's license that says "KF Donor." A few hours later, a kidney transplant operation is underway, giving new hope to a sufferer of end-stage kidney disease.

The scenario is one that has been carefully thought through by the distributors of the green stickers, the Kidney Foundation of Wisconsin. In November, 1971, the Foundation was successful in its efforts to legalize the attachment of the "Gift of Life" stickers to Wisconsin drivers' licenses. Wisconsin was the first state in the nation to pass such a law. Previously, it was illegal to affix anything to a driver's license.

The green sticker on the driver's license is a signal that the person is carrying a signed card asking that after death his body or specific organs be used for "transplantation, therapy, medical research or education."

This "uniform donor card" is good throughout the United States. Even if a prospective Wisconsin donor dies during a California vacation, his wishes to donate his body to science can be carried out.

Before the uniform donor card, eye banks, tissue banks and various local kidney foundations had developed their own donor cards. But their legality was open to question in some states and was particularly unclear when a donor from one state died in another.

With the uniform donor card donor organs can be used where death occurs without legal difficulty. Transportation of the body or organs back to the donor's home state is not necessary. In fact, in the case of donating a body for anatomical research, the University of Wisconsin can pay only the cost of transporting the body from within the state. It cannot pay for transportation of the body if the person died outside Wisconsin. The donor's estate must pay for any such expenses.

The card provides the donor with three options: (1) he may give his permission for use of any needed parts or organs; (2) he may limit his gift to specific organs or parts; or (3) he may give his entire body for anatomical study. The gift need not be limited to either a specific institution or a specific medical purpose.

The donor card must be signed in the presence of two witnesses. Neither the Kidney Foundation nor any other public or private agency keeps a list of those who have signed. If a person changes his mind, he can simply tear up the card and remove the sticker from his driver's license.

The sticker is thus the main way others know of an individual's decision. However, donors are encouraged to notify their next of kin when they sign the card to make sure their decision is known and acted upon.

The donor card was made possible in 1968 by the Uniform Anatomical Gift Act, drawn up after three years of study by the National Conference of Commissioners on Uniform State Laws. This Act and the card that goes with it have now been adopted across the nation.

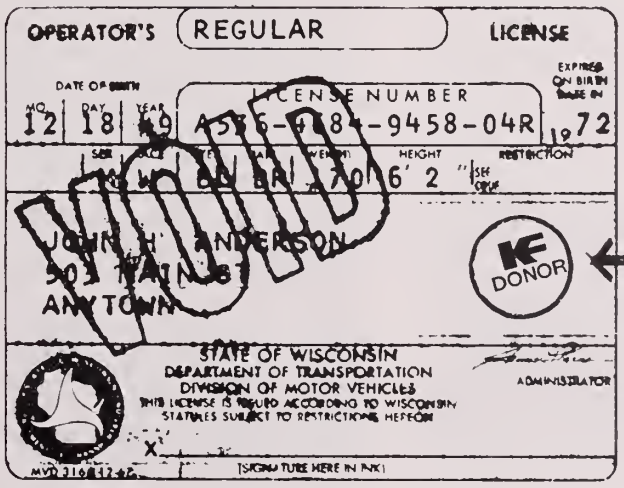
Under the Act, anyone of sound mind, 18 years or older may donate all or parts of his body for medical purposes at his death. Such a donation must take precedence over the wishes of the next of kin. However, next of kin may donate if the individual has made no directions at the time of death.

The Act provides that, in addition to a will, a donation by an individual can be made by any written document and that this "may be a card designed to be carried on the person."

The card was developed in conjunction with a number of national groups connected with transplantation and medical research. A card was felt to be the method by which the wishes of the individual have the greatest likelihood of being followed.

A protocol book has also been developed to help those in hospital emergency rooms when they receive an accident victim who has signed a donor card. Any physician in any hospital is empowered by the signature on the card to carry out the wishes of the donor. In the event this is not possible, Wisconsin has three transplant centers with teams always on call to respond. Telephone numbers of the centers are listed on the donor card: La Crosse (608) 785–0530; Madison (608) 262–2122; Milwaukee (414) 258–3011.

The donated body or organs are given to the closest site that can use them. In the case of the kidneys available for transplantation, tissue tests are immediately made and the kidney is readied for the closest match in the area based on records at the three Wisconsin transplant centers. If a match cannot be made in Wisconsin, the tissue typing information is fed into a computer that carries the names of potential tissue recipients nationwide. Again, the kidney is given to the



This dot may appear on the drivers license in the area shown here.

The donor card may be placed behind drivers license.

PKU/MR Tests Required, Newborns

All infants born in a Wisconsin hospital or maternity home by law must be subjected to a test for phenylketonuria and such other causes of mental retardation as directed by the State Department of Health and Social Services.

This is the essence of a communication to the State Medical Society by the State Health Officer, George H. Handy, MD, who recently requested the opinion of Attorney General Robert W. Warren concerning interpretation of Wisconsin Statute 146.02 (1) which reads:

"The attending physician shall cause every infant born in each hospital or maternity home, prior to its discharge therefrom, to be subjected to a test for phenylketonuria and such other causes of mental retardation under sub. (2) as the department directs."

Dr. Handy's communication follows:

"Since the results of this test cannot be expected to be valid until after the infant has been fed cow's milk for at least twenty-four hours or breast milk for at least forty-eight hours, my question to him (the Attorney General) was:

" 'Would the intent of the law be fulfilled in the case where an infant is discharged from the hospital or maternity home prior to the time that a valid test can be performed, and the parent and the attending physician enter into an agreement to have the test done at a subsequent time, as soon as valid results can be expected?'

"In the opinion of the Attorney General, the answer to my question was 'yes,' based on the principle of construction generally applied by the courts that a statute should be given an interpretation which permits a reasonable operation.

"He added: 'The burden is on the physician to have the test performed as soon as valid results can be expected so that the causes of mental retardation are not irreversible. This is the essence of the thing to be done in terms of the statutory purpose and the material provisions of the statute.

"'Although the statutory provisions carry no penalty, I regard the statute as being absolutely mandatory in terms of protecting the mental health of the infant involved. Accordingly, failure of a physician to pursue the legislative mandate in this matter may subject such physician to disciplinary action.' "

Driver's License Can Identify Organ Donor

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closest match nearest the area where the kidney is available.

The Kidney Foundation has taken a special interest in encouraging donations with the improvement of kidney transplantation techniques. With the increasing number of transplant operations, kidneys are being used as fast as they are available.

The Foundation says that a kidney transplant can reverse and cure kidney disease now claiming over 100,000 lives annually. It says over 9,000 of these can be rescued through transplant and that about 115 Wisconsin residents could benefit now from kidney transplants if the organs were available.

Marshfield HMO Claims Success

The largest rural, prepaid community health plan in the nation involving group practice has been termed a first-year success by its sponsors as enrollment was reopened in May for a second year of health care delivery.

The Greater Marshfield Community Health Plan is sponsored by the Marshfield Clinic, St. Joseph's Hospital, and Wisconsin Blue Cross and Surgical Care Blue Shield.

The Marshfield health maintenance organization (HMO) offers wide-ranging patient advantages to the 13,600 enrollees. There are no deductible, no copayment by the patients; members have free choice of physicians participating in the Plan; sick and well people may enroll and each patient is entitled to 365 days hospitalization and 70 days psychiatric care.

Rates for the first year had been set at $49.80 per family per month, $17.00 for a single person. In return, the Marshfield Clinic and St. Joseph's Hospital guaranteed complete health care services at no additional cost to the members.

David Jaye, Jr., president and administrator of St. Joseph's Hospital, said that family rates were being increased to $56.90 monthly, and single coverage would be $25.95. He cited escalation of costs of medical care and anticipated increased use of services by members as two of the reasons for the increase.

Marshfield Clinic president, Dr. David Ottensmeyer, said that year-end results showed the Plan's sponsors, including Blue Cross and Surgical Care Blue Shield, were right when they anticipated greater outgo than income the first year. The sponsors have an agreement whereby patients not a part of the Medical Plan do not participate in its subsidization, he added.

Administrator Jaye said he believed high first year costs were due in part to the large number of enrollees with pre-existing ailments such as heart and kidney disease, cancer, and stroke patients.

Jaye further noted that the greater use of outpatient and ambulatory services at the clinic and the hospital by Plan members partially contributed to their averaging a low 6.13 days for inpatient stays compared to 9.33 days for other patients. He said that more utilization of outpatient services and other services such as nursing home and home care may result in further savings.

Enrollment is limited to persons living or working in the Greater Marshfield area, including portions of Wood, Marathon and Clark County. Physicians in Pittsville, Stratford, and at the Colby Clinic have also been participating. The Plan is now being expanded to include the city of Abbotsford.

Three Students Win "History of Medicine" Awards

Three University of Wisconsin students were winners in the "History of Medicine" essay contest sponsored by the State Medical Society's Academy of Medical History and Charitable, Educational and Scientific Foundation (CESF).

Dennis Phillips, a graduate student in American diplomatic history on the Madison campus, won the first place award of $250 for his paper, "Women in Nineteenth Century Wisconsin Medicine." It will be published in an early issue of the WISCONSIN MEDICAL JOURNAL.

Janet Peth, a sophomore nursing student in Madison, received a $50 check for her paper "History of Wisconsin's Hospitals." She was a co-winner with Ronald Ellefson, a student at the University of Wisconsin–Superior. He also received $50 for his paper, "Pioneer Physicians of Wisconsin in the Nineteenth Century."

The two Madison students received their awards at the Dane County Medical Society meeting April 11 in Madison. Ellefson received his check at the April meeting of the Douglas County Medical Society.

Phillips has bachelor and master's degrees in history from North Texas State University, Denton, Tex. Miss Peth is the daughter of Mr. and Mrs. Delbert Peth of rural Malone, Wis. Mr. Ellefson is the son of Mr. and Mrs. Robert Ellefson of rural St. Croix Falls, Wis.

The prize money for the contest was donated to the CES Foundation by L. C. Pomainville, MD, Wisconsin Rapids. The awards were created as part of the Academy and Foundation's continuing efforts to preserve and chronicle Wisconsin medical history. A similar contest will be held again for the 1972–1973 academic year.

Judges for the contest were: Dr. Pomainville, State Medical Society historian and CESF treasurer; Robert T. Cooney, MD, Portage, CESF president; and G. B. Risse, MD, PhD, Madison, associate professor and chairman of the Department of the History of Medicine, University of Wisconsin–Madison.

Ronald Ellefson, second from right, receives a $50 check for his winning paper on the history of medicine in Wisconsin in the 19th century. Making the presentation on behalf of the Society's Foundation, are, from left: Dr. Thomas J. Doyle, Sr., Superior, eleventh district councilor; Dr. Robert Sellers, president-elect of the Douglas County Medical Society; Mr. Ellefson; and Dr. Charles Picard, the county society's delegate to the State Medical Society.

Dennis Phillips Janet Peth

Edgardo Jiongco, MD

. . . Fort Atkinson, recently became associated with Marvin Roesler, MD* in the x-ray department at Fort Atkinson Memorial Hospital. Doctor Jiongco completed a year of internship at Meriden Hospital, Meriden, Conn., and served his residency at Deaconess Hospital, Milwaukee.

Wis. Medical Schools Receive $24,158 Through AMA–ERF

Private funds totaling $24,158 were contributed to the two Wisconsin medical schools at a special presentation during the State Medical Society's House of Delegates' sessions in Milwaukee in May.

The University of Wisconsin Medical School received $12,029, while the Medical College of Wisconsin was given $12,129. Receiving the checks were Dr. Philip T. White, associate dean of MCW, and Dr. Richard Hong, associate dean for clinical affairs at the UW Medical School.

Presenting the checks was Dr. W. D. James, Oconomowoc, who noted that "the funds may be spent in any manner determined to be in the best interest of the schools."

The grants are part of $1,104,406 contributed in 1971 by physicians, their wives (Woman's Auxiliary to the American Medical Association), medical societies and other sources through the American Medical Association Education and Research Foundation (AMA–ERF) to medical schools in the U.S. and Canada. Some contributions are designated to specific schools; undesignated funds were divided among 122 medical schools this year.

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NEWS HIGHLIGHTS

Marshfield Clinic Foundation Names Doctor Schorr

William F. Schorr, MD,* dermatologist at the Marshfield Clinic, was elected president of the Marshfield Clinic Foundation for Medical Research and Education at the recent annual meeting of the board of directors. He succeeds Dean A. Emanuel, MD,* who was not a candidate for reelection. Paul Umhoefer was elected vice-president; Duane A. Tewksbury, secretary; and Thomas F. Nikolai, MD,* treasurer. Other board members elected to serve on the executive committee were Doctor Emanuel, Frank Hanrath, and Norbert E. Koopman. In addition to the officers and executive committee, members of the board of directors are Ronald C. Roberts, MD, Richard A. Peters, DDS, and Francis N. Lohrenz, MD* and Gerald Heinzen, James Jay, Earl Nelson, Val C. Schueller, and Vernon Baltus, the latter newly elected to fill an unexpired term.

Dr. Schorr

The Foundation's executive director, Frederick J. Wenzel, reviewed the research projects of 1971, thirty-two of which were supported from outside sources. The major supporter of the research efforts is the National Institutes of Health. From Jan. 1, 1971 through March 31, 1972, Mr. Wenzel reported that 23 projects totalling $312,660 were approved and funded from federal and other sources. Ten projects are currently pending totalling over $3.5 million. Foundation members presented 102 programs at the state, national, and international levels, the directors were told. There also were 59 scientific papers published or in press during 1971 in state, national, and international journals.

Bump Medical Group Has Open House

The new medical clinic building of the Warner S. Bump Medical Group in Rhinelander was officially recognized with an open house in May. The building committee which planned the new structure includes MDs George Pratt,* John Brown,* and Lynn Eggman* and Kurt Wendt, the clinic business manager.

The clinic was first established in 1942 by Warner S. Bump, MD.* The new facility was erected around the old structure adjacent to St. Mary's Hospital. The clinic has a staff of 11 doctors and 39 non-professionals who serve a considerable area in the northwoods with patient care count rising to almost 4,200 patient visits per month in the summer. The patient count in the winter was reported to run as high as 2,800 persons per month.

Doctor Pratt is president of the Warner S. Bump Medical Group and Doctor Brown is vice-president. Thomas Haug, MD* serves as secretary–treasurer and Marvin Wright, MD* is a member of the board.

Milwaukee Blood Center Cited for Communications Program

The Milwaukee Blood Center, Inc. and McDonald Davis & Associates, Inc., a Milwaukee communications agency, were joint recipients May 18 of a Silver Anvil Award presented by the public Relations Society of America, at a banquet in New York City. The award, one of 20 given nationally, is in recognition of an outstanding communications program carried out the previous year, and is considered the "Oscar" of the public relations field.

The public awareness program and new donor recruitment techniques at the Blood Center have allowed the Center to reach

continued on next page

PHYSICIAN BRIEFS

Paul J. Lawrence, MD*

. . . Union Grove, former physician from Southern Colony, recently assumed the position of resident physician for the Rock County Mental Hospital and Home on a part-time basis.

Burton S. Rathert, MD*

. . . Crandon physician for twenty-seven years, recently was honored for his dedicated service to the community. An "Open House" affair was held at the Crandon High School on June 4.

William F. Schorr, MD*

. . . Marshfield dermatologist, was elected to the American Dermatologic Association which met recently in Puerto Rico. Doctor Schorr presented a paper entitled "Cross Sensitivity Among the Aminoglycosidic Antibiotics." This clinical and basic research project was done in conjunction with the Marshfield Clinic Foundation for Medical Research and Education. Doctor Schorr's study of skin sensitivity revolves around 20 patients suffering from sensitivity to neomycin.

Edwin C. Albright, MD*

. . . professor of medicine at the University of Wisconsin Medical Center, Madison, was guest speaker at a recent meeting of the Winnebago County Medical Society in Oshkosh. His topic was "Treatment of Thyrotoxicosis." Doctor Albright's appearance was arranged by the Speakers Bureau of the State Medical Society of Wisconsin, through the auspices of the Society's CES Foundation.

Alphonse F. Morcinek, MD

. . . formerly of Chicago, Ill., recently opened his office in Sharon. A graduate of Poznan University, Poland, he served his residency at St. Anne's Hospital, Chicago, and previously practiced in Poland and Africa.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

PHYSICIAN BRIEFS . . .

John D. Riesch, MD*

. . . assistant clinical professor of surgery at the Medical College of Wisconsin, received the 1972 Distinguished Alumni Service Award from the University of Wisconsin—Whitewater. A 1958 graduate of the University of Wisconsin Medical School, he is a general surgeon in Menomonee Falls.

Anthony R. Curreri, MD*

. . . Madison, assistant vice-chancellor for health sciences and a professor of surgery at the University of Wisconsin Center for Health Sciences, recently was the recipient of the 1972 Civic Award for outstanding work in the field of medicine and cancer research. The award was presented by the Milwaukee chapter of Unico National.

William F. Schorr, MD*

. . . dermatologist at the Marshfield Clinic, recently was named clinical associate professor of dermatology at the University of Minnesota. Doctor Schorr will continue his practice at the Clinic and also as an associate professor at the University of Wisconsin, Madison.

Hania W. Ris, MD

. . . Madison pediatrician, in July attended the International Congress on Sex Education in Israel. She presented a paper entitled, "The Role of Education in Control of VD."

NEWS HIGHLIGHTS . . .

utopia in blood banking—all blood needs are now met by volunteer donations, said Timm M. Hurst, administrator of the Milwaukee Blood Center. The progress to 100 percent volunteer donations was accomplished despite an average 10 percent increase in blood needs each year, he noted.

The Milwaukee Blood Center is the sole provider of blood for the 33 hospitals in Milwaukee, Ozaukee, Washington, and Waukesha counties.

New Chemical Dependency Treatment Center Opens

The opening of a new chemical dependency treatment center to be operated as a unit of the Milwaukee Sanitarium Foundation, Inc., has been announced by Dean K. Roe, administrator. The center will specialize in the care and treatment of persons addicted to alcohol and other related drugs.

Mr. Roe also announced that the center has been named the Dewey Center, in memory of Dr. Richard Dewey, who was medical director of the Milwaukee Sanitarium from 1897 to 1919.

The program for the center has been endorsed by the Milwaukee County Mental Health Planning Committee, said Mr. Roe. Other groups which were consulted in the planning and supported the development of the program include the Milwaukee Council on Alcoholism, Alcoholics Annonymous, De Paul Rehabilitation Hospital, St. Michael Hospital Mental Health Center, Medical Center of Southeastern Wisconsin and the Wisconsin Division of Mental Hygiene.

Mr. Roe disclosed that the Dewey Center began accepting inquiries and arranging for patient admissions on June 19. The first patients were to be admitted on July 5.

John E. Shafer, Jr., of New Berlin has been appointed program director.

Craig Larson, MD of Wauwatosa has been named medical director and Louis F. Jermain, MD,* Wauwatosa, has been selected as internal medicine specialist.

Dewey Center is located in a three-story building on the grounds of Milwaukee Psychiatric Hospital in Wauwatosa, another unit operated by the foundation.

The Center contains 26 beds, four to serve for acute detoxification care patients and 22 beds for patients in other phases of treatment.

The 23-day program will include five components: casefinding, intake and evaluation, acute detoxification care, inpatient treatment relating to the dependency, and followup services.

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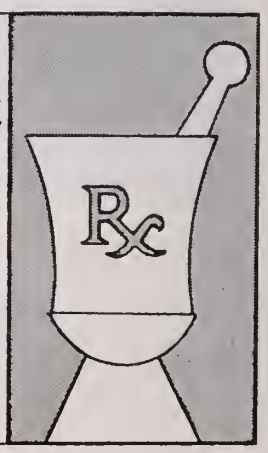

NEWS HIGHLIGHTS . . .

Waukesha Medical Society Officers Elected

John D. Riesch, MD,* of Menomonee Falls was elected president-elect of the Waukesha County Medical Society at its annual meeting June 7 in Menomonee Falls. He will assume the presidency next June.

Installed as president for the coming year was Albert J. Motzel, Jr., MD* of Waukesha, who succeeded outgoing president, Alfred E. Kritter, MD* of Waukesha.

Kenneth Dempsey, MD* of Menomonee Falls was reelected secretary and W. J. K. Clothier, MD* of Waukesha was reelected treasurer. Thomas A. Schroeder, MD* of Oconomowoc was elected to a three-year term on the Board of Censors. MDs G. Daniel Miller* of Oconomowoc, Thomas P. Belson* of Elm Grove, and Doctor Riesch were elected to serve as county delegates to the State Medical Society of Wisconsin. Thomas E. Dugan, MD* of Waukesha also serves as a delegate.

Sickle Cell Disease Screening in Madison

In late May a city-wide screening program was conducted in Madison under the sponsorship of the Madison Sickle Cell Anemia Community Organization and other concerned persons and organizations. Gov. Patrick J. Lucey also gave his support to the program. Medical coordinator of the screening tests was N. O. Calloway, MD.* Also involved in the testing was Steve Babcock, MD,* assistant director of the University Student Health Center.

Dodge Medical Society Has Newspaper Column

A weekly newspaper column on "Medical Matters" has begun in the *Beaver Dam Citizen*. Authored by the Dodge County Medical Society, the column will relate to social political, financial or paramedical problems, but particularly will relate to illnesses, their signs and symptoms, diagnosis and treatment of general interest.

Health Financing Forum Set Aug. 17–18, GBay

Alternatives to national health insurance and the Federal government's role in financing health care will be discussed at a Health Finance Symposium August 17–18 in Green Bay.

Sponsored by the Northeast Wisconsin Health Planning Council, the symposium will be held at the Beaumont Motor Inn and University of Wisconsin–Green Bay.

Subjects to be covered include: traditional health insurance mechanisms, federally financed programs, commercial health insurance, Blue Cross–Blue Shield health insurance, health maintenance and service organizations, and future health finance mechanisms.

Among the speakers will be John D. Valiante, HMO Project Manager of the Department of HEW; H. L. Livergent, Chairman of the Board of Extendicare (Canada) Ltd.; Paul W. Earle, American Hospital Association; Malcolm O. Scamahorn, MD, American Medical Association; and Steven Kurzman, Deputy Assistant for Legislation, Department of HEW.

There is a registration fee of $15 which includes dinner only on August 17. Preregistration deadline is July 31; thereafter, an additional fee of $2 will be necessary. Registration to: NE Wisconsin Health Planning Council, 828 Cherry Street, Green Bay, Wis. 54301 (registrants are asked to send a self-addressed business envelope).

An OFFICIAL NOTICE of the Wisconsin Department of Health and Social Services, Division of Health, Section of Communicable Diseases

Availability of Combined Measles/Rubella Vaccine to all Private Physicians

Tax-purchased combined Measles/Rubella vaccine is now available to private physicians for administration to children 1 through 6 years of age. Physicians who order this vaccine from the Division of Health must agree not to charge recipients for the price of the vaccine.

The vaccine is manufactured by Merck and Company, and is supplied in ½ cc doses with needle and syringe included. Physicians can order this vaccine by writing to: Section of Communicable Diseases, Division of Health, Box 309, Madison, Wisconsin 53701. Order forms for requesting re-supply will be included with the initial vaccine shipment. To avoid wasting of expensive vaccine by outdating, please order no more than a three months supply at one time.*

Combined Measles/Rubella vaccine will, of course, still be supplied to public health agencies, nursing services, and health departments, for administration to the larger 1 to 12 year age group, for any of their programs or activities. It is understood that there will be no charge for the vaccine or for its administration by these groups.

The enlargement of our combined Measles/Rubella vaccine distribution program has become necessary because infants, preschoolers, and children in kindergarten and first grade in Wisconsin continue to have low group immunization levels for both measles and rubella. The combined effort of public health and private medicine is necessary to overcome the problems these diseases pose.

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* Public Health Nursing Services and health departments may serve as depots if local demands warrant such a service.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1972

1 Madison and Area Otolaryngologists Seminar
6 Madison General Hospital Surgical Staff
6 Madison Urological Soc.
6 Madison Anesthesiol. Soc.
6 Dane County Medical Society Board of Trustees
7 SMS President's Reception and Dinner
9 SMS Commission on Scientific Medicine
10 SMS Commission on Medical Care Plans
12 MEDIHC Operating Committee
13 State Medical Exam. Bd.
14 State Medical Exam. Bd.
15 State Medical Exam. Bd.
19 State Pharmacy Board Exams
20 American Board of Internal Medicine Exams
21 American Board of Internal Medicine Exams
22 SMS Committee on Cancer
23 Ad Hoc Committee on Open Heart Surgery, Health Planning Council
27 Board Exams for Professional Nurses
27 SMS Division on School Health
28 Board Exams for Professional Nurses
28 Scientific Program Committee, 1973 SMS Annual Meeting
29 Ad Hoc Committee on Chiropractic
29 WPS–Blue Shield Program for Medical Assistants

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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NEWS HIGHLIGHTS . . .

Sheboygan Physicians Honored

Community Better Life Awards were presented recently to two Sheboygan physicians "in recognition of unselfish and dedicated efforts in behalf of better health care of the aged." Robert A. Keller, MD* (left) and Paul P. Bassewitz, MD* (center) are shown above receiving plaques from Chris Schmidt, administrator of Morningside Nursing Home which gave the awards for the doctors' many years of service on the Home's medical advisory committee and utilization review committee. The awards were presented under guidelines established by the American Nursing Home Association. (SHEBOYGAN PRESS Photo)

Medical Personnel Cited by Wisconsin Heart

William P. Young, MD,* a Madison cardiovascular surgeon, and Kathleen Robedeaux, a Milwaukee nurse specializing in cardiology, were named Wisconsin's outstanding physician and nurse for 1972 by the Wisconsin Heart Association. The awards were announced at the Association's Annual Dinner and Business Meeting held June 3 in Madison.

Dr. Young

It was the first annual presentation of the Awards of Distinction which honor outstanding "dedication and contribution to Heart's mission." The award plaques were presented by John H. Morledge, MD,* 1972–73 president of Wisconsin Heart.

Doctor Young is a professor of cardiovascular surgery at the University of Wisconsin Medical Center, Madison, and is a practicing surgeon. He was honored as Outstanding Physician for his "achievements in the expert care of patients with cardiovascular disease, his infinite compassion for patients, and his interest in the education and contributions of all health professionals."

Miss Robedeaux is the staff nurse in the cardiology department of the Milwaukee County General Hospital. She was named Outstanding Nurse for her "compassionate care of the cardiovascular patient, her understanding and application of new knowledge, and her clinical expertise."

Other officers for the year were also elected by the membership at the annual Wisconsin Heart affair. They include: Sam N. Sherman of Milwaukee, chairman of the Board of Directors; H. David Friedberg, MD* of Milwaukee, president-elect; Miss Margaret Anderson, RN, MSN of Madison, secretary; and Merton Knisely of Milwaukee, treasurer.

NEWS HIGHLIGHTS . . .

Dr. Pomainville Given Beaumont Painting Replica

The State Medical Society's historian, Leland C. Pomainville, MD* of Wisconsin Rapids, displays a copy of a painting depicting Dr. William Beaumont examining Alexis St. Martin, a gunshot victim whom Dr. Beaumont used for his studies of the human digestive system in 1820 at Fort Crawford in Prairie du Chien. The picture was presented to Dr. Pomainville for his work in medical history by Wyeth Laboratories, Inc., Philadelphia, Pa. (Photo courtesy WISCONSIN RAPIDS TRIBUNE)

PHYSICIAN BRIEFS . . .

Ayaz M. Samadani, MD*

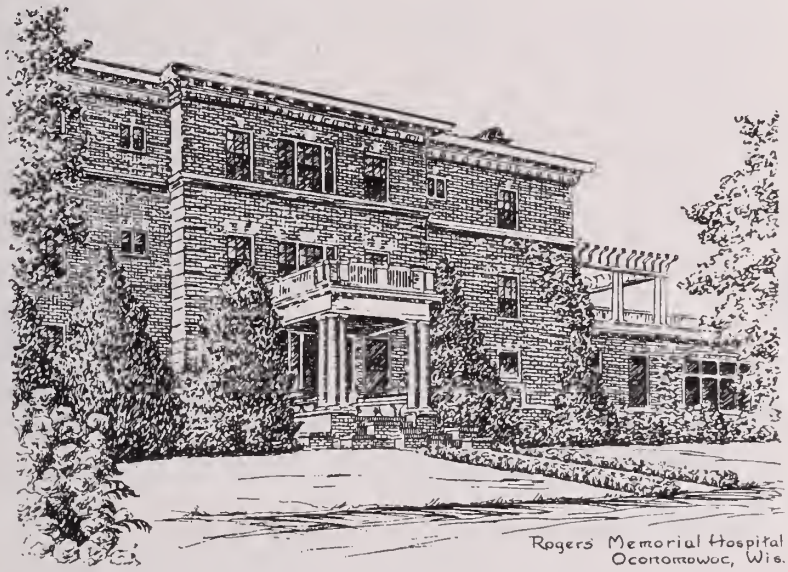
. . . physician and surgeon of the Cambria Medical Clinic and Beaver Dam Medical Center, will serve as the medical director for the Continental Manor Nursing Home in Randolph.

Richard Ellingstad, MD

. . . Burlington, recently joined MDs Lief Erickson,* Laird McNeel* and George Krismer* of the Burlington Clinic. He graduated from the University of Wisconsin Medical School in 1968 and recently returned from two years of missionary service at Nkoaranga Hospital, Tanzania, Africa.

William Rock, MD*

. . . Madison, vice-president of the Dane County Medical Society, recently received an Outstanding Alumnus Award for 1972 from St. Mary's College, Winona, Minn. □



MEDICAL STAFF

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Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
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AMERICAN MEDICAL ASSOCIATION has launched a new canvass of blood banks in the United States. Survey seeks data for 1972 edition of *Directory of Blood Banking and Transfusion Facilities and Services,* a publication of the AMA since 1958. Cooperation of all facilities which draw or transfuse blood or blood plasma products is being sought to make the 1972 directory useful in determining the state of blood banking in America. Survey is being conducted by the AMA with cooperation of American Association of Blood Banks, American National Red Cross, American Hospital Association, Council of Community Blood Centers, Division of Biologics Standards of National Institutes of Health, and National Blood Resources Program of National Heart and Lung Institute. Free copies of directory will be provided to all blood facilities responding to survey, AMA states. Blood facilities which have not received a survey form are requested to notify the AMA's Committee on Transfusion and Transplantation, 535 North Dearborn St., Chicago, Ill. 60610. □

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NEWS HIGHLIGHTS . . .

William W. Grover, Jr., MD of Bonduel (left) presents awards to John E. Dettmann of Green Bay (center) and Ray Fulwiler, Sr. of Algoma (right). Doctor Dettmann was one of five physicians to be honored by the Northeast Wisconsin Health Planning Council at its first annual meeting in June. Mr. Fulwiler, a Kewaunee County Board member, was instrumental in the start of the three-year-old organization. (GREEN BAY PRESS–GAZETTE Photo)

Northeastern Wisconsin Doctors Honored

The Northeast Wisconsin Health Planning Council in June honored a number of area persons who have been instrumental in the three-year-old organization's efforts at resolving health care problems. Among those honored were five physicians: MDs John E. Dettmann* of Green Bay for his health planning efforts predating the Council to 1963; John M. Bell* of Marinette for his efforts including cooperative arrangements between Marinette, Wis., and Menominee, Mich., in health care matters; William C. Randolph* of Manitowoc for taking the initiative three years ago to seek his county's membership in the nine-county body; Francis Heise* of Tigerton for "shouldering the responsibility for rural health care" in his area; and George H. Handy* of Madison, now State Health Officer and formerly the first director of the State Bureau of Health Planning that he helped NEWHPC and other regions to organize. The doctors were presented awards by William W. Grover, Jr., MD* of Bonduel, who was reelected president at this first annual meeting of the Council. Counties represented in the Council are: Brown, Door, Kewaunee, Manitowoc, Marinette, Menominee, Oconto, Shawano, and Sheboygan.

Oconto Falls Community Memorial Hospital Moves

The Oconto Falls Community Memorial Hospital moved into a new $2 million facility this Spring at the southeast edge of Green Bay. Its present administrator, Edward Stein, is on loan from the University of Wisconsin. A 12-doctor family clinic is attached to the hospital and shares x-ray and laboratory units with the hospital, although each is a separate corporate structure.

Dr. Chamberlain

Dr. John Chamberlain Elected to Marquette Alumni Post

John O. Chamberlain, MD* of Shorewood was elected president-elect of the Marquette–MCW Medical Alumni Association at its annual meeting May 10 in Milwaukee. Doctor Chamberlain, a 1952 graduate of the medical school, is an internist in private practice in Milwaukee. He is currently chief of the medical staff at Columbia Hospital in Milwaukee.

As president-elect, he will take office as president of the Alumni Association in May 1973, succeeding Joseph S. Devitt, MD* of Shorewood, who was installed as president during the May 10 dinner affair. Doctor Devitt, a general practitioner and a 1939 graduate of the medical school, succeeded Paul A. Dudenhoefer, MD* of Elm Grove, a 1951 graduate who served two terms as president. Doctor Dudenhoefer was presented with a special award for his service.

Robert F. Purtell, Jr., MD* Brookfield, was reelected secretary-treasurer and Robert Leitschuh, MD,* Racine, was elected to the board of directors.

John G. Walsh, MD, Sacramento, Calif., a 1938 graduate, was honored as the 1972 "Alumnus of the Year." A family doctor in Sacramento, Doctor Walsh is a past president of the American Academy of Family Physicians.

Section on Plastic Surgery Officers

At the May Annual Meeting of the State Medical Society, the Section on Plastic Surgery elected the following officers for the coming year: chairman—Gordon Davenport, MD,* Madison; vice-chairman—Paul Natvig, MD,* Milwaukee; and secretary, John Hamacher, MD,* Madison. Ruedi P. Gingrass, MD* of Milwaukee was elected as both the Section's delegate to the State Medical Society's House of Delegates and as its representative on the Commission on Public Policy. Doctor Natvig will serve as alternate delegate.

Wausau Hospitals Plan Emergency Service

A Regional Emergency Medical Center was opened July 1 at Wausau Hospital North. MDs George R. Hammes,* Arthur W. Hoessel,* and Richard C. Shannon,* all of Wausau, are providing the continuous, on-site, 24-hour physician coverage. The new center is a consolidation of emergency rooms at Wausau Hospital North and Wausau Hospital South. The three physicians have given up their practices at the Wausau Clinic to provide the emergency coverage. There are five more physicians expected in Wausau some time this month to provide additional medical service to the community.

College of Cardiology Fellowships

Four Wisconsin doctors have been granted Fellowships in the American College of Cardiology (ACC), the national medical society for specialists in cardiovascular diseases. The doctors are among a group of 193 from United States and Canada recently admitted to the College's highest membership classification.

John H. Huston, MD,* Milwaukee, the ACC Governor for Wisconsin, listed the new Fellows as: William C. Boake, MD, Madison; Burton J. Friedman, MD,* Nathan Grossman, MD,* John C. Manley, MD* all from Milwaukee.

The doctors, as well as the other new Fellows, have fulfilled stringent membership requirements based on several years of practice and specialty certification.

Doctor Huston also was elected to a three-year term as a Governor of the college. The Governors are concerned with furthering the growth of the organization in specific geographical areas —and in encouraging continued interest and active participation in the College's activities.

The American College of Cardiology represents 5,000 accredited and certified specialists in cardiology and related disciplines. It has as its primary goal the development and maintenance of excellence in cardiac care. □

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OBITUARIES

George B. Hildebrand, MD, 63, Neenah, died Mar. 23, 1972, in Neenah.

Born Oct. 17, 1908, in Huntington, Ind., he graduated from the University of Chicago School of Medicine in 1941 and served his internship at University Hospital, Ann Arbor, Mich. Doctor Hildebrand served in the United States Army Medical Corps during World War II and was discharged in 1946. He was affiliated with the Riverside Clinic, Menasha, and was on the staff of Theda Clark Memorial Hospital.

Surviving are his widow, Elizabeth; a daughter, Mrs. Robert (Jean) Billings, Columbus, Ohio; and two sons, Philip, Menomonee, Mich., and Stephen, Ann Arbor, Mich.

Arthur G. Maercklein, MD, 93, Racine, died Apr. 21, 1972, in Burlington.

Born on Sept. 29, 1878, in Milwaukee, Doctor Maercklein graduated from the Milwaukee Medical College in 1903. He was a general practitioner in northern Wisconsin for many years and spent four years at Union Grove as district surgeon for the government and worked in CCC camps for eight years. He retired in 1950.

Surviving are two daughters, Mrs. Alex (Edith) Thome, Racine, and Mrs. Winston (Pat) Weygand, Burlington; and one son, A. Richard Maercklein, a chief petty officer in the Navy at Norfolk, Va.

Robert James DeWitt, MD, 36, Marinette, died Apr. 25, 1972, in Marinette.

Born on Apr. 2, 1936, in Marinette, Doctor DeWitt graduated from Columbia University College of Physicians and Surgeons in 1961 and took his internship at Mary Fletcher Hospital and his residency at the University of Vermont hospitals. He had been on the staff of the Marinette Medical Clinic since 1966 and was a fellow of the American College of Surgeons.

He was a member of the Marinette County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Laurene; and two daughters, Robin and Dawn, Marinette.

John E. Rueth, MD, 82, Wauwatosa, died Apr. 25, 1972, in Fond du Lac.

Born on Feb. 21, 1890, in Sun Prairie, Doctor Rueth graduated from Marquette University School of Medicine in 1915, served his internship at Trinity Hospital, Milwaukee, and residency at Deaconess Hospital, Milwaukee. Doctor Rueth was a founder of the Milwaukee Medical Center which was established in 1936 and dissolved in 1957. He entered private practice and retired in 1970. He served with the United States Army Medical Corps in World War I.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Avis; a son, John E., Milwaukee; and two daughters, Mrs. Paul Reichardt, Sierra Madre, Calif., and Mrs. John Abelt, Brookfield.

Elmer C. Kocovsky, MD, 65, Milwaukee, died Apr. 26, 1972, in Milwaukee.

Born on Sept. 2, 1906, in Milwaukee, Doctor Kocovsky graduated from Marquette University School of Medicine in 1933 and served his internship and residency at Milwaukee County General Hospital. He served in the United States Army Medical Corps during World War II. Doctor Kocovsky was head of the Department of Physical Medicine and Rehabilitation at Trinity Memorial Hospital. He was president of the Wisconsin Association of Physical Medicine and served both as chairman of an accreditation committee and president of the Wisconsin Nursing Home Association. In 1968, Doctor Kocovsky was appointed to the State Medical Society's Division on Rehabilitation.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Frances; a son, Robert, Wauwatosa; and a daughter, Mary Anne, Milwaukee.

Lawrence L. Larsen, MD, 50, Milwaukee, died May 1, 1972, in Milwaukee.

Born Apr. 28, 1922, in Oconto Falls, Doctor Larsen graduated from the Jefferson Medical College in Philadelphia in 1949 and served his internship at Milwaukee County General Hospital. He served in the United States Army Medical Corps in 1951–52 and was a member of the medical staff of St. Michael's Hospital, Milwaukee.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Iris; two sons, Dennis and Mark, and two daughters, Suzanne and Elizabeth, Milwaukee.

Karl J. Borsack, MD, 85, Fond du Lac, died May 6, 1972, in Fond du Lac.

Born on Nov. 27, 1887, in Eldora, Iowa, Doctor Borsack graduated from Rush Medical College in 1921 and served his internship at Cook County Hospital, Chicago. Doctor Borsack was associated with the Wiley–Smith Clinic in Fond du Lac, and was a member of the "50 Year Club" of the State Medical Society of Wisconsin.

He also was a member of the Fond du Lac County Medical Society and the American Medical Association.

Surviving is his widow.

Robert C. Wolf, MD, 70, Hales Corners, died May 10, 1972, in Milwaukee.

Born Oct. 16, 1901, in Milwaukee, Doctor Wolf graduated from Creighton University School of Medicine in 1927 and served his internship at the Good Samaritan Hospital, Cincinnati, Ohio. He practiced in Hales Corners for 35 years before resigning in 1964 due to ill health. He served as health officer for Oak Creek, Franklin, Greenfield, and

Hales Corners. Doctor Wolf was on the medical staff of St. Luke's and Lutheran hospitals of Milwaukee. He also served in the United States Army Medical Corps during World War II.

He was a member of the American Academy of Family Physicians, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Marjorie, and a daughter, Mrs. Ben (Corabelle) Lonning of Hales Corners.

Simon C. Weisfeldt, MD, 59, Whitefish Bay, died May 13, 1972, in Whitefish Bay.

Born on Oct. 14, 1912, in Milwaukee, Doctor Weisfeldt graduated from Marquette University School of Medicine in 1935 and served his internship at Milwaukee County General Hospital. His residency was taken at Misericordia Hospital. He practiced in Milwaukee until 1941, when he enlisted in the United States Army Medical Corps and served in the South Pacific. He returned to Milwaukee in 1945. Doctor Weisfeldt was on the speakers' bureau of the Wisconsin Heart Association, a member of the Industrial Medical Association, the Central States Society of Industrial Medicine and Surgery, and the Medical College of Wisconsin Medical Alumni Association.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Sophia, and a son, Dr. Myron L. of Boston, Mass.

Robert E. Fitzgerald, MD, 87, Milwaukee, died June 7, 1972, in Milwaukee.

Born Feb. 6, 1885, in Cedarburg, Doctor Fitzgerald graduated from Marquette University School of Medicine in 1912 and served his internship at Milwaukee County Hospital for Mental Diseases. Doctor Fitzgerald was a former chief of staff of St. Joseph's Hospital, Milwaukee, and was honored for his 39 years of service to the hospital. He was a State Medical Society councilor from the 12th District from 1940–1948 and in 1966 received the Council Award from the State Medical Society. He was chairman for Wisconsin's procurement and assignment service of physicians of World War II and was honored for his service to the state and nation. Doctor Fitzgerald also was chairman of the State Medical Society's Committee on Grievances from 1950–1960 and became a life member of the Society in 1967.

He also was a member of The Medical Society of Milwaukee County and American Medical Association.

Surviving is a daughter, Margaret of Milwaukee. □

PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual.* Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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Hanson, James C., 1111 Delafield St., Waukesha 53186
Harned, Gerald L., 223 Wisconsin Ave., Waukesha 53186
Keller, Theodore A., P. O. Box 427, Menomonee Falls 53051
Kennedy, Brian W., 2388 North Lake Dr., Milwaukee 53211
Klein, William C., 8700 West Wisconsin Ave., Milwaukee 53226
Landstrom, Donald L., P. O. Box 427, Menomonee Falls 53051
Musgjerd, David G., 4072 Terrace Dr., La Crosse 54601
Palay, Howard J., 400 Roselawn Blvd., Green Bay 54301
Raisinghani, Mohini, 5000 West National Ave., Milwaukee 53214
Tamayo, Primo R., 2711 West Wells St., Milwaukee 53208
Tyne, Lee M., 17030 West North Ave., Brookfield 53005
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Washa, Darryl M., 709 South Tenth St., La Crosse 54601

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Churchill, Bernard P., 14002 Cameo Dr., Sun City, Ariz. 85351
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Craig, James L., West 8th St., New Richmond 54017
Deeds, Ernest C., 1826 Eastwood Ave., Janesville 53545
Diancin, Renato C., 545 Dix St., Columbus 53925
Doshi, Harshad V., Grasslands Hospital, Valhalla, N. Y. 10595
Dvorak, Paul F., 7102 Colony Dr., Madison 53717
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Fabiny, Robert J., 733 West Clairmont Ave., Eau Claire 54701
Fisher, Albert L., P. O. Box 834, La Crosse 54601
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Gani, Mukhtar A., 2266 North Prospect Ave., Milwaukee 53202
Garner, Lawrence L., P. O. Box 1608, Milwaukee 53201
Geldner, Barbara, 240—1st St., Neenah 54956
Gungor, Bahri O., 216 Sunset Pl., Neillsville 54456
Hansen, Arthur C., 2565 North 84th St., Wauwatosa 53226
Helm, Frederic C., 3700 North Main St., Vancouver, Wash. 98660
Hibma, Otto V., 20 S. Park St., Madison 53715
Horning, John S., Box 626, Jos, Benue—Plateau State, Nigeria, West Africa
Irwin, Wallace G., 109—1st St., Lodi 53555
Janusonis, Palmira A., W347 S4948 C.T.H. "G", Dousman 53118
Kallas, Gerald J., 2266 North Prospect Ave., Milwaukee 53202
Kamstra, Egbert, 2163—20th Ave. Monroe 53566
Kennan, Alfred L., 1020 Regent St., Madison 53715
Kirkham, Bruce C., 3737 Claymore Lane, Eau Claire 54701
Klieger, Jack A., 161 West Wisconsin Ave., Milwaukee 53203
Konz, Stephen A., 26 Bellaire Court, Appleton 54911
Kwapy, Clemens R., 8849 Jackson Park Blvd., Wauwatosa 53226
Lacke, Clement L., 4929 Whitcomb Dr., Madison 53711
Land, James F., 710 Huron Hill, Madison 53711
Lawrence, Paul J., 2600 East Racine St., Janesville 53545
Leh, Patrick S. S., 1745 Dousman, Green Bay 54303
Manz, Kenneth F., 216 Sunset Place, Neillsville 54456
Massart, John J., 161 West Wisconsin Ave., Milwaukee 53203
McGinnis, James P., 106 Belknap Plaza, Superior 54880
McMahon, Arthur E., 2211 Stout Rd., Menomonie 54751
Miner, Delbert L., Route #1, Box 463, East Troy 53120
Moritz, Walter D., Route #4, Box 239, Fort Atkinson 53538
Mudge, William A., Jr., 419 East Arch St., Marquette, Mich. 49855
Mueller, Gustav G., 503 West Water St., Princeton 54968
Nesbit, Mark E., 22 Fuller Dr., Madison 53704
Ozturk, Cahit H., 216 Sunset Pl., Neillsville 54456
Pelton, Russell S., P. O. Box 187, 315 Mt. Zion Drive, Ripon 54971
Rastetter, Joseph W., 545 North 15th St., Milwaukee 53233
Rens, John L., 1659 Capital Ave., Madison 53705
Rogers, Raymond J., Route #1, Box 49, Oconto 54153
Rouse, John J., P. O. Box 348, Reedsburg 53959
Russo, John G., Route #4, Kaukauna 54130
Santilli, Robert J., 7909 North Links Circle, Milwaukee 53217
Scholter, Edmund A., 2015 North Lake Dr., Milwaukee 53202
Skemp, Samuel J., 815 South 10th St., La Crosse 54601
Thompson, Thomas N., 216 Sunset Place, Neillsville 54456
Wilson, Janet A., 6814 Donna Dr., Middleton 53562

DEATHS

O'Keefe, Francis L., Walworth County, May 14, 1972
Stehr, Arthur C., Dane County, May 22, 1972
Carroll, Paul E., Waukesha County, May 31, 1972
Fitzgerald, Robert E., Milwaukee County, June 7, 1972
Saketos, Theodore P., Milwaukee County, June 14, 1972
Silbar, Sidney J., Milwaukee County, June 15, 1972 □

ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Hypnosis: Is It for You?. Hypnosis is not a cure-all and it's not a mystery, but misconceptions about it are rampant. Lewis R. Wolberg, MD, a pioneer in the use of hypnosis, objectively examines its assets and limitations in his new book, published May 24 by Harcourt Brace Jovanovich, Inc., 757 Third Ave., New York, N. Y. 10017. Dr. Margaret Meade calls *Hypnosis: Is It for You?* "a lucid, well-balanced, authoritative account of just what hypnosis can and cannot do."

Guidelines in EEG. A new series of publications of the American Electroencephalographic Society, with information of potential use to physicians, technologists, nurses, hospital administrators, and others directly or indirectly concerned with electroencephalography. Three titles are presently available: No. 1—*Minimum Technical Standards for EEG Recording in Suspected Cerebral Death*, No. 2—*Minimum Technical Requirements for Performing Clinical Electroencephalography*, and No. 3—*Standards of Practice in Clinical Electroencephalography*. Other titles will be added to the series in time. Copies of the *Guidelines* are available for $1.00 each (to help defray printing and postage costs) upon request to: Mrs. Margaret H. Henry, Executive Secretary, The American EEG Society, 36391 Maple Grove Road, Willoughby Hills, Ohio 44094.

FILMS

Ready . . . or Not?, a fourteen minute color movie suitable for television or community groups, was given its first public showing early in June by Employers Insurance of Wausau, the company which sponsored and produced it. The new film is a dramatic plea to individuals to get themselves "emergency ready" in case they find themselves the first on the scene of a serious accident. The film's message is delivered through a hypothetical family camping accident and an auto accident. It stresses capability for securing the accident scene and dealing with life threatening situations such as a breathing crisis, severe bleeding, and spinal injuries. Available from either the Film Librarian, Employers Insurance of Wausau, 2000 Westwood Dr., Wausau, Wis. 54401, or Modern Talking Pictures, 1909 Prudential Plaza, Chicago, Ill. 60601.

ANNOUNCEMENTS

TO THE SMS AUXILIARY: The new *Physicians Desk Reference* for 1972 is on the doctor's desk. Get the 1971 issue away from him and send it to the state auxiliary chairman below. Physicians in foreign countries are begging for these books for their own reference work. This is our opportunity to help in the practice of good medicine all over the world. An international health project.—Mrs. W. G. Meier, 917 Woodland Road, Kohler, Wis. 53044.

FIRST AID CHART. A newly revised first aid chart, 10x14 inches, is now available in limited quantities (maximum 25) by request to WPS Blue Shield, Advertising Department, Box 1109, Madison, Wis. 53701. Copy has been clarified or changed in particular areas to coincide with the new first aid techniques suggested by the American Academy of Pediatrics and the medical profession in general.

A SEARCH IS ON FOR OLD EQUIPMENT, photographs, and manuscripts that will help illustrate 200 years of physical medicine and rehabilitation practice in America. The search is a joint effort of the Smithsonian Institution, the American Congress of Rehabilitation Medicine and the American Academy of Physical Medicine and Rehabilitation.

The Smithsonian has agreed to display an exhibit in 1973 tracing the development of this branch of medicine. The exhibit will call attention to the 50th anniversary meeting of the American Congress of Rehabilitation Medicine, a national scientific organization whose membership includes physicians, nurses, physical therapists, occupational therapists, speech pathologists, social workers, vocational counselors, psychologists and biomedical engineers.

Among the items being sought for the display are old canes, crutches, wheelchairs, exercise devices, heat therapy and hydrotherapy equipment, braces, splints —in short, any materials or equipment associated with the rehabilitation of the physically handicapped.

The Smithsonian Institution will pay crating and shipping charges for any equipment selected for the exhibit. In addition, the names of all donors will be listed in the exhibit catalog and will be indicated on the particular item.

The ACRM, which will hold its 50th Annual Session in Washington, D. C., October 21–26, 1973, has invited anyone with articles of historical interest to the field of physical medicine and rehabilitation to contact Thomas P. Anderson, MD, Department of PM&R, 860 Mayo, University of Minnesota Hospitals, Minneapolis, Minn. 55455. □

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

Aug. 17–18: Symposium on Health Finance Mechanisms, Northeastern Wisconsin Health Planning Council, Beaumont Motor Hotel and University of Wisconsin–Green Bay, Green Bay.

Aug. 28–Sept. 1: Emergency Care Course, American Academy of Orthopaedic Surgeons, at Madison. Course chairman: Kenneth M. Sachtjen, MD, 2715 Marshall Court, Madison, Wis. 53705.

Sept. 6–8: Tenth Annual Cancer Chemotherapy Conference, University of Wisconsin, Madison. Info: Dr. G. Ramirez, 714-C University Hospitals, Madison, Wis. 53706.

Sept. 14–16: Annual Fall Meeting, Wisconsin Society of Internal Medicine, joint meeting with American College of Physicians, Holiday Inn, La Crosse.

Sept. 15–17: Annual Meeting, Wisconsin Radiological Society, Pioneer Inn, Oshkosh.

Sept. 19: Symposium on Primary Prevention of Heart Attack—Consumer Health Education, Hotel Pfister, Milwaukee.

Sept. 23: Cancer Conference, Marshfield Clinic Foundation for Medical Research and Wisconsin Division of American Cancer Society, Marshfield.

Sept. 23–24: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Oct. 6–7: Wisconsin Society of Obstetrics and Gynecology, Pioneer Inn, Oshkosh.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

1972 NEIGHBORING STATES

Aug. 7–10: American Health Congress '72, Chicago–McCormick Place, Chicago, Ill. Info: Call Mrs. Ruth Blaine, 312/645–8220.

Oct. 14–20: Annual Otolaryngologic Assembly of 1972, Eye and Ear Infirmary of University of Illinois Hospital, Chicago, Ill. Info: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 13–18: Course in Laryngology and Bronchoesophagology, Department of Otolaryngology of Abraham Lincoln School of Medicine and University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill. Info: Dept of Oto., U of Ill. Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

continued on next page

CONTRIBUTIONS—CES FOUNDATION

May 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for May 1972:

Nonrestricted

State Medical Society Members	Voluntary contributions of 81 MDs
Columbia–Marquette–Adams County Medical Society	Contribution
State Medical Society	Memorials: R. J. DeWitt, MD, J. E. Rueth, MD, E. C. Kocovsky, MD, L. L. Larsen, MD, K. K. Borsack, MD, R. C. Wolf, MD, S. C. Weisfeldt, MD
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Joan Pyre, Marguerite Cordts, Mr. & Mrs. Earl R. Thayer, Mavis & Reese Minor, Doris Jordan, Frances H. Ryan, Margaret K. Pharo, Mr. & Mrs. Marvin Luther, Thomas L. O'Meara	Memorial: Mrs. Wendell A. Anderson
John & Mina Satory	Memorial: Mrs. Arnold Cook
Barbara & Howard Brower	Memorial: Mr. William Deming
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Dr. & Mrs. E. J. Nordby	Memorials: Elmer R. Gesteland, Arthur Stehr, MD

Memorials

State Medical Society Members	Voluntary contribution of 1 MD

Student Loans

State Medical Society Members	Voluntary contributions of 4 MDs

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 3 MDs

George Hilliard, Jr., MD, Fellowship Fund

State Medical Society Members	Voluntary contribution of 1 MD

Charitable Disabled Physicians

George R. Andrews, MD	Contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: John Steen

W. W. Hildebrand & G. B. Hildebrand, MD Memorial Account

Carolyn G. Strang	Memorial: George Hildebrand, MD
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Popp Student Loan Fund

Albert Popp, MD	Contribution

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Medical Student Summer Externship Program

Thomas S. Westcott, MD, New Richmond Clinic, Louis Weisbrod, MD, Walter Lewinnek, MD, Dodgeville Clinic, General Clinic–Antigo, T. C. Fox, MD, Robert Heinen, MD, Forrest E. Zantow, MD, Cumberland Clinic, Robert M. Anderson, MD, Wallace G. Irwin, MD, Leonard B. Torkelson, MD, Lester Olson, MD, R. W. Matzke, MD, F. Goetsch, MD, Marwood E. Wegner, MD, George Nemec, MD, Frederick A. Melms, MD, Wisconsin Physicians Service, John D. Hart, MD, R. L. Logeman, MD, W. E. Rosenkranz, MD, B. G. Garber, MD, R. E. Housner, MD, Robert Sellers, MD, Albert H. Stahmer, MD, Kenneth L. Strebe, MD — Contributions □

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trends

The Wisconsin Regional Medical Program, Inc.

JULY, 1972

Wisconsin RMP Receives $1,265,816 for Statewide Emergency Medical Service Project

Grant is Largest Ever Received For One Project

An Emergency Medical Service (EMS) program that will tie together statewide communications networks and establish training programs to meet on-site emergency situations was approved for $1,265,816 by Regional Medical Programs Service, Division of Health, Education and Welfare (HEW), Washington, D.C.

The announcement was made jointly by Judge Rodney Lee Young, Chairman, Wisconsin Regional Medical Program's Regional Advisory Group and Dr. John S. Hirschboeck, Program Coordinator for the Wisconsin Regional Medical Program (Wisconsin RMP).

The grant was made to the Wisconsin RMP for two years. It is the largest ever received by the Wisconsin RMP for a single program.

Under the terms of the grant, the Wisconsin RMP will assume overall responsibility for the program, but will turn much of the organizational responsibilities over to the Wisconsin Hospital Association.

The EMS program will establish a comprehensive, systemized network of communications and personnel training which is expected to reduce the mortality and morbidity of acute medical and surgical emergencies in Wisconsin.

"The program is expected to improve the quality of medical care delivered at the site of the emergency, while the patient is in transit and in the emergency department of the hospital through coordinated planning and improved training programs for on-site technicians (ambulance personnel) as well as hospital emergency personnel," Young said. "To achieve this, however, will require the close coordination and cooperation of the many hospitals, medical societies, health organizations, Wisconsin Division of Health, Comprehensive Health Planning and other state and county agencies, as well as educational and professional association and health planning agencies."

"The EMS program is probably the most important program ever introduced to Wisconsin to improve the quality of emergency medical service through a systemized network of communications and facilities with qualified medical staff immediately available," he continued. "It is this complete communications system, from the site of the emergency to the hospital, that will improve care and decrease the mortality rate in emergency situations throughout the state."

The various components of the EMS program will be coordinated by a group of representatives from fourteen state, health and medical agencies and nineteen other agencies, as well as consumers concerned with meeting all types of emergency needs in Wisconsin.

"The coordinating body of the EMS program will have a most important responsibility if the program is to succeed," Dr. Hirschboeck said. "There is little doubt in my mind that the versatility and expertise of those involved will provide Wisconsin with one of the

(Continued on Page 2)

Wisconsin RMP Moving Sept. 1

The Wisconsin RMP will move to new locations in Milwaukee and Madison on September 1.

The new addresses will be:

MILWAUKEE:
735 N. 5th St.
Milwaukee, Wis. 53203

Telephones in Milwaukee will stay the same:

272-3636

MADISON:
Wisconsin Hospital Assoc. Bldg.
P. O. Box 4387
Madison, Wis. 53711

Mail List To Be Ready About Sept. 1

A comprehensive mailing list of health and allied health organizations, institutions, and individuals is being developed by the Wisconsin RMP to help facilitate professional health and education groups with their programs throughout the state.

During the past several months, the Wisconsin RMP has been asked about the availability of a mail listing to meet needs throughout Wisconsin. Educational institutions sponsoring health and allied health seminars pertaining to community, state and national health issues, as well as health and allied health organizations, have expressed a need for a list of this kind.

Through the cooperation of the Medical College of Wisconsin and agreements with groups from throughout the state, the Wisconsin RMP will be making the list available about September 1, 1972. The list contains approximately 30,000 names and addresses and will be used only with the approval of cooperating agencies. The list, available at cost, will be used primarily for the dissemination of information on health and education activities and in no way will be made available for commercial purposes. Additions and corrections to the listing will be handled through the Wisconsin RMP at no cost to individual organizations.

There is no fee for having your organization become part of the list. For further information contact:

Peter A. Kirsch, Director —
Public Information, Wisconsin RMP, 110 E. Wisconsin Avenue, Milwaukee, Wisconsin 53202.

EMERGENCY MEDICAL SERVICE

Many Agencies To Direct Project

(Continued from Page 1)

finest emergency medical service systems in the country . . . a system that the citizens of Wisconsin will be most proud and a system that is expected to provide the most efficient emergency care possible in any and all parts of Wisconsin."

In order to meet the long range objectives of reducing the mortality and morbidity rate in acute emergencies situations, the EMS program will:

1. Establish localized volunteer councils and coordinate local resources to improve emergency services on a regional basis.

2. Initiate, conduct and expand training programs for on-site emergency medical care personnel and hospital emergency department personnel.

3. Devise a state resource plan to categorize all Wisconsin hospitals in terms of levels of service.

4. Improve utilization and effectiveness of urban hospital emergency departments.

5. Assist the Division of Highway Safety and the Division of Health in completing a statewide microwave communication system to interconnect ambulance vehicles, dispatchers, hospitals and other emergency services.

6. Coordinate highway safety programs which help link hospital communications equipment and emergency vehicles with the EMS system.

7. Train EMS dispatchers to assist in routing emergency vehicles to appropriate emergency facilities.

8. Provide information to the public making them aware of the existence of the emergency care system.

9. Aid in securing legislation which would establish standards for emergency medical service manpower needs and facilities.

10. Coordinate the identification of Wisconsin highways designating the location of hospital emergency services through the cooperation of the Wisconsin Department of Transportation.

11. Design and develop emergency vehicles to meet emergency needs in urban areas.

12. Assist comprehensive health planning agencies in helping to provide state as well as community emergency planning needs.

The agencies involved in organizing the development of the Wisconsin Regional Medical Program project are: Wisconsin Hospital Association; State of Wisconsin—Division of Health and the Bureau of Comprehensive Health Planning; Medical Society of Wisconsin; State of Wisconsin—Division of Highway Safety; Comprehensive Health Planning Agency for Southeastern Wisconsin, Milwaukee; Health Planning Council, Madison; Lake Winnebago Areawide Comprehensive Health Planning Council, Fond du Lac; Northeastern Wisconsin Health Planning Council, Green Bay; North Central Area Health Planning Association, Merrill; Northwest Areawide Comprehensive Health Planning Organization, Superior; West Central Wisconsin Health Planning Council, Menomonie; Western Wisconsin Health Planning Organization, La Crosse.

Other participating organizations are: American College of Surgeons; Employers Insurance of Wausau; Forward Communications, Inc.; Hospital Council of Greater Milwaukee Area; Medical Center of Southeastern Wisconsin; Medical College of Wisconsin; Medical Society of Milwaukee County; Milwaukee County Institutions and Departments; Milwaukee County Office of Emergency Government; University of Wisconsin, School of Nursing, Madison; State of Wisconsin—Department of Transportation; State of Wisconsin Governor's Health Policy and Program Council; Tri-State Ambulance Service, Inc.; University Hospitals, Center for Health Sciences, University of Wisconsin Extension; University of Wisconsin Instrumentation Systems Center; University of Wisconsin Medical School; Wisconsin State Fire Chiefs Association.

"The Real Thing" Shows Need For Emergency Know How

In discussing the need for an Emergency Medical Service (EMS) program in Wisconsin, Dr. Joseph Darin, Chairman, Wisconsin Trauma Committee, American College of Surgeons, relates the following:

"Recently, two Milwaukee people were in an automobile accident near a small town located about 40 miles from Milwaukee," Dr. Darin said. "The pair was taken to the nearest hospital, but because of severe head injuries suffered by one of the accident victims, the pair wanted to be transferred to Milwaukee County Hospital. The physician at the small hospital agreed that the transfer should be made because of inadequate facilities to meet the immediate needs of the accident victims.

"The physician called county hospital," Dr. Darin continued. "Not knowing the severity of the accident or the condition of the patients, we immediately dispatched two ambulances with a physician in each vehicle and equipped them with what we thought would be necessary to meet the emergency."

Dr. Darin noted that the entire situation was based on very few facts and resulted in a waste of time and manpower. In short, an inefficient system of meeting emergency needs.

"We did not have a communications link available which, at the time, would have been most valuable to us, the hospital in the small town, and most important, the victims of the accident," Dr. Darin said. "Because of this inefficiency, medical manpower and equipment were temporarily lost and consequently inadequately utilized. More important, there was a great loss of time in getting the patients to a facility to meet their individual needs."

"Emergencies should not be handled by hospitals with inadequate facilities in meeting specific emergency needs," he continued. "Accident victims as well as others involved in medical emergencies should be taken directly to a facility with the capability of providing all the care necessary to meet the immediate needs of patients. If this is impossible because of the severity of a particular situation, trained personnel from larger facilities should be available to fly in to assist the smaller facility when the need arises. Most emergencies do not require elaborate equipment and facilities but rather specially trained people."

"This is what the Emergency Medical Service (EMS) program is all about," Dr. Darin added, "providing emergency care to everyone in Wisconsin through an efficient utilization of manpower, facilities and equipment eliminating costly duplication, inefficiency and most important, minimizing the time involved in providing adequate emergency medical care."

Emergency Medical Services

By

JOHN S. HIRSCHBOECK, M.D.

Program Coordinator

It has been said that an emergency exists when someone decides that it exists. A baby swallows a button, and a worried mother calls upon the emergency medical system to do something about it. She may call the police, or fire department, her physician, a hospital, the medical society, or the neighbor next door. The response is apt to be different in each case. The mobilization of an emergency response may effectively and efficiently meet the need, or it may be inappropriate, inadequate, and possibly even harmful.

It is the goal of the Wisconsin Regional Medical Program Emergency Medical Service (EMS) Program to rationalize the loosely organized and sometimes inefficient emergency medical service system in Wisconsin into a comprehensive program concerned with public education, legislation, sharing of services, education and training of personnel, classification of hospitals according to their capability to deal with emergencies, planning for continuing improvement through support of Areawide Health Planning Agencies.

Emergency service is not just ambulance service, nor is it concerned only with highway accidents. It accommodates the person with heart disease or stroke as well as trauma — even a baby who has swallowed a button.

Persons who opt for service in hospital emergency rooms rather than attempt to locate their personal physician are increasing in number to such an extent that they interfere with the efficient care of true emergencies.

Highway accidents involve the rich and the poor, regardless of color. The improvement of emergency health services must be everyone's concern. It will, however, be the specific concern of the Wisconsin Regional Medical Program to further the development of cooperative arrangements within health care system and governmental agencies to build an operating organization which is dedicated to collaborate, to build and operate an effective consortium which is responsible to the public.

Advisory Group OK's $156,490 in Proposal Requests; Will Begin Jan. 1 if Approved By RMPS in Washington

Proposals Include Shared Services, Preadmission Testing

Proposals totaling $156,490 have been approved by the Regional Advisory Group of the Wisconsin RMP at its June 7-8 meeting at Lake Delton. The proposals have been sent to Regional Medical Programs Service, Washington, D.C., to be included in the application for next year's funds.

The proposals are the result of project offering requests made earlier this year by the Wisconsin RMP.

Three projects approved by the Advisory Group, were submitted by six St. Croix Valley hospitals and thirteen hospitals in western Wisconsin (Comprehensive Health Planning Area 5) and another project by five hospitals in the Madison area. All three will establish mechanisms or systems for shared services on a regional basis.

The fourth request, made by Trinity Memorial Hospital, Cudahy, will help determine the merits of preadmission testing on a large scale basis.

If approved, the projects will begin January 1, 1973.

"Shared services on a regional basis is one of the most important factors of reducing costs of health care delivery," said Judge Rodney Lee Young, Regional Advisory Group Chairman. "It is important for people to look at themselves and their community or region to see whether or not a more efficient utilization of resources might not be achieved. It is only through this kind of coordinated effort that the people in Wisconsin are going to experience progress being made in health care delivery."

Hospitals cooperating in shared services in the St. Croix Valley area are: Baldwin Community Hospital; Hudson Memorial Hospital; Holy Family Hospital, New Richmond; Ladd Memorial Hospital, Osceola; St. Joseph Hospital, River Falls; St. Croix Valley Memorial Hospital, St. Croix Falls.

Eleven hospitals also cooperating in a shared services project are from the western region or La Crosse-Eau Claire area. The project will establish Shared Health Services Corporation and provide medical, para-medical and support services in addition to those already being provided on a pilot basis.

Shared services presently being provided include: neonatal intensive care unit, cardiac catheterization lab, renal dialysis and kidney transplant, nuclear medicine, home care programs, ambulance attendant training, computer services and others.

The Madison hospitals, which make up the Madison Council of Chiefs of Staff and Administrators are: Madison General, Methodist, St. Mary's, University Hospitals and Veterans Hospital. The hospitals have been working together since 1968 and have successfully implemented a shared services program on a limited basis. Funding from the Wisconsin RMP is expected to accelerate the program by establishing full-time external coordination.

Trinity Memorial Hospital, Cudahy, will study the feasibility of wide scale preadmission testing for hospitals throughout the Wisconsin Region.

"The study will result in pre-operative patients having their lab work and necessary x-rays done as outpatients prior to surgery," said Dr. Paul C. Tracy, WRMP Associate Coordinator. "It is assumed that this kind of program will result in a better psychological attitude on the part of the patient because the one or two day hospital stay will be eliminated. Also, this project is expected to cut hospital costs and utilize personnel and equipment more efficiently because of the ability to schedule patient testing during regular working hours.

"Although the activity carried out in all three projects is not new, the scope and evaluation of each project has never been carried out in Wisconsin," Dr. Tracy said. "In order to achieve an improved health care delivery system in Wisconsin we must have a basis for evaluating what has already been done. This is what we hope to achieve."

Judge Rodney Lee Young (left), Chairman of the Regional Advisory Group talks with Dr John S. Hirschboeck, Wisconsin RMP Coordinator, after receiving a gavel in appreciation for service during the past six years. He was chairman of the Advisory Group for the past four years.

Eight Original Members of Advisory Group Attend Final Meeting at Wisconsin Dells

Eight members of the Wisconsin RMP Regional Advisory Group attended their last meeting at Lake Delton, June 7-8. All were members of the original Advisory Group in 1966 when the Wisconsin Regional Medical Program was organized.

Attending their last meeting were: Judge Rodney Lee Young,

Judge Young

Regional Advisory Group Chairman, Ladysmith; Dr. Russell F. Lewis, Vice Chairman, Marshfield Clinic, Marshfield; Arthur Benkert, Attorney, Monroe; Harold C. Guntner, Hospital Council of Greater Milwaukee, Milwaukee; Harold E. Helterhoff, Minocqua; Walter L. Larson, Ashland; Adele G. Stahl, Administrator, State Division of Nurses, Madison, E. J. Surwillo, D.D.S., Wisconsin State Dental Society.

According to the by-laws of the Wisconsin RMP, no member of the Regional Advisory Group can serve more than six successive years.

"I am privileged to have served as Chairman of the Advisory Group

Dr Lewis

Benkert

for four years," Judge Young commented. "I have enjoyed working with all members of the Group and staff who have demonstrated sincere dedication and high professional judgment in moving the Wisconsin RMP in a direction that has given it the credibility and foresight in bringing about improvements in our health care delivery system.

"I would like to think each of us, as individuals, had a great deal to do with the success to date," he added. "The credit belongs to all

Guntner

Helterhoff

members who worked so diligently as a team. I'm grateful for having been part of this great team for the past six years."

Judge Young was the second Chairman of the Advisory Group. T. A. Duckworth, President, Wisconsin RMP, was the original Chairman of the Committee.

Miss Stahl noted that, with the termination of the formal relationship as a member of the Advisory Group, the full cooperation of the State of Wisconsin, Division of

Larson

Stahl

Nurses should still be expected whenever and wherever necessary.

"It is important for the state departments and the Wisconsin RMP to continue to coordinate and cooperate in ventures to improve the health care in Wisconsin," she said. "Because of the very fine relationship enjoyed in the past, I expect that we might be working even more closely than in the past because of the many immediate health needs presently confronting federal, state and local governments."

Helterhoff, Larson, Benkert and Dr. Lewis expressed appreciation for giving the smaller communities in the state a voice in programming statewide activities.

"The one thing the Wisconsin RMP has not done is forget the rural population located in the greater portion of the state," Helterhoff said. "Now that there is even greater involvement at the

Dr. Surwillo

smaller community level, I hope I can keep my fingers in it some way."

During the past six years, Guntner has been deeply involved in the activities of the Wisconsin RMP. Most recently, he served as Chairman of the Review and Evaluations Committee.

"The Wisconsin Regional Medical Program is most grateful for the great amount of time and effort these people have given to our program," said Dr. John S. Hirschboeck, Wisconsin RMP Coordinator. "The desire for improvement in the delivery of health care, their concern for quality performance at the provider level as well as quality care at the patient level, coupled with equitable accessibility for those in rural as well as urban areas played a major role in the effectiveness of our programs in the state. I know they have established a firm base of cooperation and coordination that will help us build for the future."

Three New Members Appointed to Wisconsin RMP Board of Directors

RE-ELECTED

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Donald C. Stichter
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Dr. John S. Hirschboeck
Sec.-Treas

Eugene W. Arnett

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Albert W. Jache

Del C. Jacobus

Dr. Henry C. Pitot

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Peter A. Kirsch

Facts About Emergency Medical Service

(Taken from a report by Paul F. Markgren, Wisconsin Hospital Association)

Radio Communications Network —

1969 — Seven general hospitals in Wisconsin had two-way short wave communications potential with local ambulance service.

Presently, 67 hospitals are in process of purchasing radio communications equipment joining emergency room with ambulance service.

Provision of Ambulance Services —

1969 — Division of Health survey revealed of 531 ambulance services in state — 37% made fewer than 50 runs last year.

EMS program will make efforts to regionalize these services to improve quality of patient care through more intense utilization of personnel.

Ambulance Attendant Training —

The Section on Emergency Health Services, Division of Health, has been conducting training programs for the past two years. Approximately 900 ambulance drivers and attendants have completed the course.

The EMS program will coordinate additional programs with the two medical schools in Wisconsin for advanced training for emergency medical technicians. There are approximately 7,200 ambulance drivers and attendants in Wisconsin qualified for the program.

Highway Signing of Hospital Emergency Rooms —

At the present time there is no emergency facility identification on Wisconsin highways.

EMS programs will categorize hospital emergency facility capabilities and identify these capabilities along Wisconsin highways. This project will be coordinated through the Traffic Safety Division, Department of Transportation.

the wisconsin medical journal

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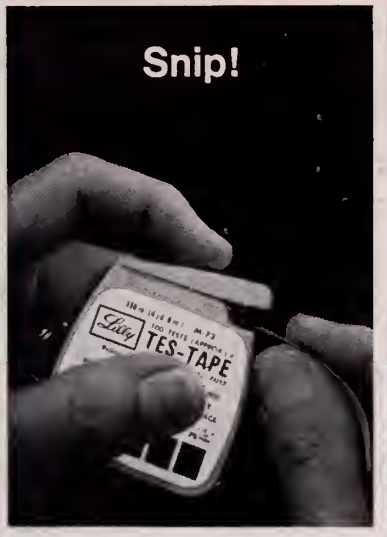
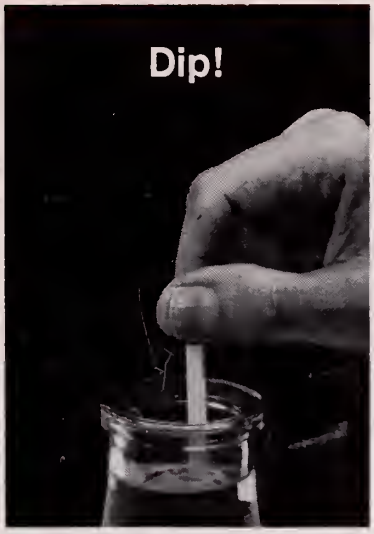
AUGUST 1972





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PRESIDENT'S PAGE

The Blue Plans in Wisconsin

Today physicians and patients alike have come to accept Blue Cross and Blue Shield as an almost necessary part of their health care. Commercial insurance has likewise done a remarkable job in developing excellent hospital–medical health plans, but it was the Blue Plans in the early days of this social experiment that led the way. Almost half of the citizens of our State enjoy the hospital and surgical–medical protection of the Blue Cross–Blue Shield plans. All three plans have been in service for over a quarter century and each one enjoys an enviable record of good management and service to the people of Wisconsin. Indeed, all three plans are in the top bracket among the Blue Cross–Blue Shield plans across the nation.

Sometime in the distant future historians may recount the story of the stormy early days of the Blue Cross–Blue Shield plans in Wisconsin. It was a completely new, untried social experiment. The idea of a nonprofit prepaid voluntary scheme of collecting and paying hospitals and doctors' charges was hard to accept by some doctors and hospitals alike. The problem of who would control these plans; the problem of financial stability; the existing State Statutes that had to be amended to allow the development of the plans, all conspired to add fuel to the turmoil. The Birth of the Blues in Wisconsin was a noisy, bitter, protracted event. In the years that followed public acceptance and faith in the plans spun a success story that was hard to believe.

It would be quite impossible to estimate the dollar value of the physician and lay leader contribution that has been given so freely in the development and successful operation of these three plans. The citizens of our State indeed owe a great debt to the unselfish, unpaid man hours spent in this quest for better health care for us all. The ultimate beneficiary of this great and good effort, of course, is written in the millions of hospital and medical records of the Blue Plan subscriber and his family. It is a record that will not quickly tarnish.

It has been my great privilege over the past three decades to have been involved in assisting in the development or management of all three Blue Plans. I am immensely proud of the medical benefits that these plans have brought to our people in Wisconsin. Surely the good Lord has blessed us all.

Robert F. Purtell, MD

Editorials

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WISCONSIN
MEDICAL JOURNAL

Guilt—American Style

MOST PHYSICIANS HAVE come into their practice believing that their role in life was to relieve human suffering and disease. This sometimes is learned in medical school, sometimes follows naturally from the puritan ethics of his family and sometimes from both. This essentially fixed picture of ourselves—as physicians and healers—is jarred by many things happening at all political levels.

Physicians are told—as they were a few weeks ago in Milwaukee—that unless medical care, of higher quality than ever, is brought by us to all the people, rich or poor, we will soon be forced to do so. The phrasing was of this order: get the message by words, or on the end of a fire bomb. The speaker did not mean that he would throw the fire bomb, but that physicians' failure to supply full medical care would precipitate forceful methods of getting our attention. We also are told, over and over, that our opposition to allied health groups and the cult of chiropractic is based on greed and a desire to deprive Americans of proper health care, by depriving them of their right to choose their method. We also are told that we make too much money and do not give satisfactory service or care to our patients and that this must stop.

Consider for a moment, not the specific complaints, but the effect of this sort of complaint on persons trained as we are, from highly selected starting material. It seems only reasonable that we should react with shock, then fury, to be told that those very values we thought were so much a part of us and which we believe we are practicing, are simply not true. That others—and so many others at that—should see us so differently than we see ourselves, can produce anxiety, anger, and sometimes confusion. It is from this confusion that wrong thinking, often wrong judgments can come, hence some introspection might well be in order.

When a man's picture of himself is challenged, so strongly and persistently as not to be ignored, he has several things he can do. He can rant and rave and insist that all detractors are malcontents at the least, and Marcusean at the worst. This is an interesting and lively position that can be managed with great vehemence by some when baited sufficiently. To attack the character and intentions of our critics is a sure way to avoid discussion of ourselves and our ways, and makes good sport as well.

That is, it makes good sport if we are winning. But what if the "other" side is simply more vocal than we, more verbally effective by training than we are by our medical training, or worse if they have taken hold of a social issue which is simply broader than the practice of medicine. In this latter circumstance both they and we are guilty of aiming wrong. If persons in poverty areas, for example, have several times as much disease as those in affluent communities, should they attack us for not going into such areas and treating the disease; or, could they with any conscience better turn their efforts to the problems of poverty itself. On the other side, is spirited counter aggression our best (or even effective) method to deal with such attacks. It seems possible to disqualify ourselves as social, political and economic experts, and to insist that our medical training is simply more specific than that required to meet all problems of the world, but that as responsible citizens we certainly will listen to all proposals to this end.

Another scheme some physicians follow when confronted this way, is to mobilize their own guilt feelings, which have always told them anyway that they could really never do enough for mankind. In this fashion the already busy doctor starts to give time to this clinic or that school or some other community venture, until his service week approaches 70 or 80 hours per week. Certainly a few persons get extra service but what about the man's family, what about the bulk of his practice when he exhausts himself completely and can no longer serve; and last but not least, what is gained for the physician himself, who has allowed his own feelings of guilt to be whipped into a frenzy by those who would demand more and more of him. To drain an extra fifty percent of energy (or twenty percent) from all doctors may be the solution to problems of health delivery, poverty, and a part of the road to the good life, but I don't really think so.

Still another device to deal with this stirring of our sense of guilt (not to be confused with actual guilt), is simply to practice without reference to such attacks. This is most dangerous for it leaves us with neither information about our adversary nor plans of procedure. This, in our rapidly shifting world, is unconscionable, although perhaps comfortable for awhile.

No matter what you call it, integrity, puritan ethics, morality, social sense or simply humanism, we need to think through who and where we are, and to make those things known. We must know and press for those things in which we are competent. We can also participate in other areas, but as citizens not as doctors, else we violate our own code. The few caricatures of attitudes mentioned above do not make a catalogue. Perhaps they will look sufficiently familiar that we can reconsider just how best to manage the present threat. My particular solution may not be any better than some other. My contribution, I hope, will be to alert physicians to the variety of responses possible, some of which are based on an over-reaction to our own sincerity. It is rapidly becoming American style to manipulate groups such as ours, not directly but by means of unspoken, though certainly not unknown feelings. This sort of guilt, based on doing more and more, could be our vulnerable spot.—RH

The Political Year

By May 9, 1972, it was apparent to all physicians as they read the resolutions and viewed the actions of the House of Delegates that concern about the political events that had transpired during the legislative year was acute. This belief and a feeling of frustration seemed to cast a veil over the delegates. Where had medicine missed its mark with legislators and the Governor's office? Why was medicine ineffective in stopping the stampede of bills that undermine the safety of the health of our citizens by actions favorable to a vocal minority professing a service based on quackery?

This political setback should be a reminder for all members of the State Medical Society to be involved—now. This must be THE POLITICAL YEAR of the Society and all of its members.

Although I have been an officer of your Society for only several months, it seems strikingly clear to me that our homework must be done relating to those legislators who profess our belief in our system of free enterprise.

The 1973 Legislature will be expected to react to Governor Lucey's Task Force reports and legislative bills. (See July Green Sheet.) Will you be prepared to help forestall a legislative thrust directed at altering your system of care? Will you have the legislative muscle to carry on the State Medical Society's positive programs which it feels are important to your patients?

The decision to act must occur now during the primary elections and subsequent November contests. Don't expect your lobbyist to do in Madison what you are unable to do in your own community. Support the candidate of your choice—do it now—we need your help. This is the political year.—Gerald J. Derus, MD, Madison

* * *

P.S. You will have the opportunity to "be involved" in regional meetings for physicians on legislative and other matters which have been scheduled as follows:

September 13–14, Madison and Milwaukee
20–21, Appleton and Wausau
27–28, La Crosse and Rice Lake □

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Potential Need and Standards for Development of Cardiac Surgery in Wisconsin

CHARLES W. LEMKE, MS
GEORGE G. ROWE, MD
Madison, Wisconsin

PUBLIC CONCERN with the cost and quality of medical care has resulted in the development of comprehensive health planning agencies. The Governor's Health Policy and Planning Task Force is concerned with the development and implementation of acceptable standards for medical services. This is reflected as well within the medical profession and its program of peer review.

Cardiac surgery is a rapidly growing field, and it undoubtedly will continue to grow. Currently about 40 percent of all deaths in Wisconsin result from diseases of the heart. Even after medical research finds adequate ways for preventing heart disease, there will remain a backlog of victims for many years; therefore, the continued need for surgical therapy seems certain. Cardiac catheterization and cardiac surgery are very delicate and exacting procedures that require much training and a large investment in equipment, facilities, and personnel. These facts emphasize and dictate the need for standards in the development of cardiac surgery and its supportive services within Wisconsin.

However, the simple existence of standards is not enough. They must be implemented; and if purposeful planning is to take place, then information on the potential need is essential. This article provides both a set of standards and a means of estimating the need.

Standards

Planning agencies and hospitals considering the development of cardiac surgery units are asking for guidelines or standards to solve the problems that accompany the development of cardiac surgery programs. To help meet these requests the Wisconsin Regional Medical Program (WRMP) on April 6, 1972, convened a group of eminently qualified cardiologists and cardiovascular surgeons from around the State for the purpose of developing and ratifying a set of standards for the establishment of cardiac surgery units in Wisconsin. Those present were: MDs Dean Emanuel, Marshfield; Erik Gundersen, La Crosse; Harold Harding, Appleton; Donald Kahn, Madison; Ben Lawton, Marshfield; Francis Rosenbaum, Milwaukee; George Rowe, Madison; and Daniel Thearle, Green Bay. The result of their efforts is set forth below, as agreed by all, in the Standards for Development of Cardiac Surgery Units in Wisconsin.

It should be noted, however, that these are minimum standards and should not be regarded as optimal or ideal. The growth of knowledge and experience in cardiac surgery will inevitably lead to innovations and the rapid development of new procedures. For these reasons periodic revision of these standards will be necessary, although it is unlikely that the standards will become less exacting.

* * *

Standards for Development of Cardiac Surgery Units in Wisconsin

I. INSTITUTION

A. Facilities

1. Diagnostic and surgical facilities should be combined:
   a. Physically, locating these services in the same building is acceptable. The ideal situation is to have them located in adjacent rooms.
   b. Programatically, the institution should require that the diagnostic and surgical teams meet regularly and that they are available to each other for consultation during procedures.
2. An adequate diagnostic facility includes at least:
   a. Cardiac catheterization and angiocardiographic laboratory
   b. Pulmonary function unit
   c. General hospital chemistry laboratory
   d. Blood gas analysis laboratory
   e. Microbiology laboratory
   f. Hematologic laboratory
   g. Blood bank
   h. The committee further makes a strong recommendation that renal dialysis should be available in the same institution.
3. Postoperative cardiac intensive care recovery unit must have as a minimal requirement the following:
   a. Adequate beds and monitoring equipment to insure that all surgical patients will receive the same level of care for at least an average of 72 hours, or for as long as required.

Mr. Lemke is Evaluations Coordinator for the Wisconsin Regional Medical Program (WRMP); Doctor Rowe is a former member of the Revue and Evaluation Committee of WRMP. He is also Professor of Medicine, University of Wisconsin Medical Center.

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b. Resuscitation equipment located strategically within unit.
c. All cardiac surgery patients should be grouped to insure efficient use of equipment and personnel. (Grouped does not imply an open ward.)

4. An intermediate intensive care unit (step down unit) with monitoring and resuscitation capabilities and specialized nursing care (more specialized than in general nursing, but less than required for intensive care nursing) for all cardiac surgery patients is very desirable.

5. Special cardiac operating rooms:
   a. Must be large enough to comfortably and safely accommodate the operating staff, the patient and all necessary equipment. The National Inter-Society Commission on Heart Disease Resources has found that the minimum acceptable size is in the range of 24 x 26 feet.
   b. For a center planning more than six procedures per week two rooms are required.
   c. Should have well organized storage of supplies in the operating suite.
   d. Should have four separate sources of suction for each operating room.
   e. National Fire Protection Association Code 56 and U.S.P.H.S. Pub. #930 A-7 as modified in 1969 to provide minimum specification for air handling:
      (1) 12–15 changes per hour
      (2) 60° to 75°
      (3) 50–55% humidity
      (4) High Efficiency Particulate Air (HEPA) filtering of incoming air
      (5) Exhaust, passive
      (6) Appropriately located air intakes.

6. It is essential that consultation of a competent biomedical engineer be sought for the purpose of advising on purchase of equipment, on maintenance and evaluation of new and old equipment, and to assure adequate:
   a. Radio frequency shielding
   b. Electrical hazard control in the operating room recovery units and intensive care units
   c. Alternate sources of electrical power that are designed to assure continuity of electrical power in emergencies.

B. Staff

The following levels of staffing are recommended for an institution that is performing the recommended minimum of four open heart surgical cases per week.

1. Institution must provide access to adequate staff qualified and capable of maintaining all equipment needed for surgery, as well as for the postoperative cardiac intensive care recovery unit, and also the intermediate, or "step down" intensive care unit.

2. Institution must provide adequate staff, qualified and capable of operating equipment needed for performance of cardiac surgery, monitoring and maintaining all cardiac surgery patients in an intensive postoperative care recovery unit, and monitoring and maintaining all cardiac surgery patients in an intermediate intensive care unit.

3. It is recommended that planning efforts be so designed that anticipated volume will allow the cardiac surgical team to devote its efforts exclusively to cardiac surgery.

4. The postoperative cardiac intensive care recovery unit administrative director can be an MD, and a member of the cardiac surgery team—overall postoperative care must remain the responsibility of the surgeon.

C. Program

1. Cardiac surgery units must be supported by laboratory facilities for testing procedures and equipment to keep abreast of new developments and training technical personnel.

2. It is desirable that there be a reasonable system of transportation and referral within Wisconsin.

II. TEAM

1. Disciplines included on team must be broadly based and integrated by the following preparatory components.
   a. New units must have established initial competence by preliminary surgery in a dog laboratory.
   b. Surgeons shall participate in preoperative diagnostic and management conferences; they must be responsible for patients during surgery and the postoperative recovery period.

2. Development of a team should not be considered unless a minimum of four cardiac surgical procedures per week can be assured.

3. A cardiac surgery team to perform the recommended minimum number of procedures should

consist of at least the following number of each:

a. Cardiac surgeons—2
b. Operating room nursing personnel (RN, LPN, Surgical Technician)—4
c. Anesthesiologists—2
d. Adult cardiologists—2
e. Pediatric cardiologist—1
f. Radiologists—2
g. Pathologists—2
h. Biomedical Engineer—1
i. Pump and monitoring technicians—2
j. Other surgical assistants—2
k. Laboratory support technicians—2

4. No program should be considered unless a minimum of one American Board of Thoracic Surgery certified surgeon with a minimum of two years of experience in an active cardiac surgery unit after his thoracic surgical residency, and an American Board of Thoracic Surgery qualified surgeon are both available and committed to active participation in this program.

III. REGIONAL CONSIDERATIONS

1. An areawide cardiac surgery planning group should be organized to advise the areawide comprehensive health planning "B" agency prior to the establishment of a cardiac surgery unit at any institution within the area.
2. Activities of an areawide cardiac surgery planing group should include:
   a. An analysis of available information on the number of cases that may need cardiac surgery.
   b. Steps to insure that there is a unified cardiac surgery program that will insure orderly development of surgical services.
   c. Planning that will prevent development of new cardiac surgery programs until existing programs have reached the agreed upon optimum case load, or their intended capacity, or that it is clear that the needed goal is not likely to be reached.
   d. Development of measures to prevent equipping a cardiac surgical unit until:
      (1) The team is committed to serve in the institution.
      (2) The institution provides assurance that it is seriously involved in and cooperating with a peer review or quality assurance program within its own staff as well as within a larger regional group.
3. The areawide planning group should consider the development of a total program that includes early discovery and diagnosis of cardiac patients, and referral to the type of institution providing the most appropriate care for the individual case.
4. A regional arrangement for interchange of information on results of surgical procedures between cardiac surgery units is very desirable.

This concludes the presentation of the Standards agreed upon by the group convened on April 6, 1972.

* * *

Potential Need for Diagnostic and Surgical Units

Two prime factors are essential to assure that a cardiac surgery unit can reach the recommended minimum of four cases per week. The first of these is communication and collaboration among planning groups and professionals within the area that is to be served, as well as between neighboring areas and whole regions. The second is a reasonable estimate of the potential number of cases that can be expected from a given area. Estimation of the potential depends, in turn, upon two factors: need and demand. Need can be estimated rather easily. Demand, however, depends upon a combination of factors: knowledge and desires of the patient, existing complications of the patient's cardiac problem such as other diseases, and the experience, knowledge, and referral habits of the patient's physician.

The mechanism for communication is available through the already established areawide health planning groups (the CHP "B" agencies). The foregoing standards and their own bylaws suggest how they may work. The remainder of this article is devoted to a presentation of information that is available at this time for the purpose of estimating the potential number of patients that may need cardiac surgery.

A. Existing Cardiac Surgery Units

Figure 1 is an outline map of Wisconsin and surrounding states showing the approximate location and approximate number of hospitals that are active in cardiac surgery. This was adapted from a survey of surgical services done by Regional Medical Programs Service, and partially updated by calls to knowledgeable people in surrounding states. It emphasizes the fact that cardiac surgery is widely available. Simply looking at the distribution of existing units does not answer the questions of referral patterns or present volume of cases. It is clear, however, that it would not be advisable to plan on a greater patient potential than can be generated by the population of any given planning area. It seems reasonable to assume that patients will eventually be referred chiefly to the nearest facility, assuming equal skills develop. For this reason all further data will be presented on the basis of the patient's residence, rather than the area in which the patient was treated.

Figure 2 is a map of Wisconsin showing the boundaries of the eight areawide comprehensive health planning agencies. These areas are coincident with the eight uniform administrative districts established by the State in 1970. They are identified by numbers and all succeeding references to district

Figure 1—Approximate location of hospitals reporting heart surgery in Wisconsin and surrounding states, 1972. [Source: 1970 Special Hospital Services for Cardiovascular Disease Patients, Volume II—Surgical Service (updated by personal communication).]

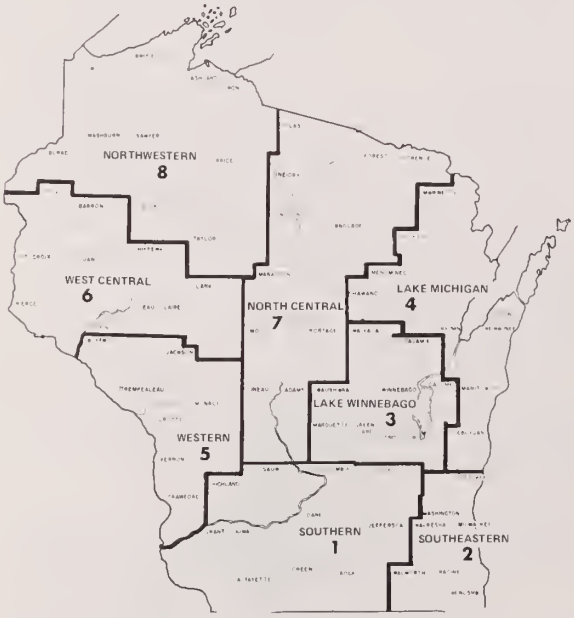

Figure 2—Wisconsin's eight areawide comprehensive health planning agencies, 1972.

numbers will refer to the areas as outlined in Figure 2.

B. Estimating the Potential Need

Mortality records are valuable but are of minimal use for our purpose. They do not reflect the conditions of the living population with whom we are primarily concerned. For instance, they do not necessarily reflect the distribution of morbidity by age which is an important factor in estimating the need for diagnostic facilities and surgery.

Fortunately there are two other sources of information that are more applicable to the problem. The first consists of results from the Health History Questionnaire which was administered with the multiphasic case finding program of the Bureau of Preventable Diseases, State Division of Health, Department of Health and Social Services, in 1968–1970. The second source is a survey of the diagnoses of subjects discharged from hospitals in Wisconsin.

In the first study a total of 83,107 persons responded to the question, "Has a doctor ever said you had heart disease?". Whereas this is an admittedly inadequate screening procedure, it may supply a rough approximation of the magnitude of the problem. Table 1 summarizes the response by broad age groups for residents of each of the eight administrative areas of the State. Age specific rates from the response were applied to the comparable age group from the 1970 census of population to extrapolate the estimated numbers of "walking" sick. The nature of the survey excluded institutionalized and homebound persons from the sample, but they were included in the population estimates; therefore, the number of sick persons may be under-estimated. Additionally, those persons whose physicians have not seen fit to inform them of the fact that they have heart disease could not have answered "yes" to the question. On the other hand, it is well accepted that people who make the most use of services of multiphasic screening programs may be symptomatic and thus may provide biased data for some purposes.

The percentage of Wisconsin's population aged 20 years and over with heart disease based on this questionnaire is 5.5. A national survey produced an estimate of 5.0 for the non-institutionalized population aged 18 through 79 years. These percentages are not directly comparable because of differences in the methods of the surveys and because of the differences in the age groups. Wisconsin's survey includes a slightly older population. This would tend to make Wisconsin's rate higher than the national rate.

TABLE 1—*Total number of persons with heart disease estimated from response to health history questions, Multiphasic Case Finding Program, by administrative district of residence and age—Wisconsin: 1968–1970*

Administrative District	Persons with Heart Disease, by Age Group (Years)					
	20–44	45–54	55–64	65–74	75+	Total
1	4,202	2,730	4,435	6,454	6,088	23,909
2	9,500	7,059	11,207	14,950	12,379	55,095
3	2,368	1,621	2,796	4,122	3,756	14,663
4	2,503	1,892	3,229	4,639	3,955	16,119
5	1,031	824	1,464	2,302	2,164	7,785
6	1,588	1,136	2,037	3,157	2,965	10,883
7	1,720	1,261	2,262	3,390	2,773	11,316
8	737	642	1,326	1,979	1,750	6,434
Total	23,649	17,075	28,756	40,894	35,830	146,204
Percent of Grand Total	16.1	11.7	19.7	28.0	24.5	100

SOURCE: Health History Questions from the Multiphasic Case Finding Program—Wisconsin: 1968–1970. Bureau of Preventable Diseases, and prepared by the Section of Statistical Services, Bureau of Health Statistics, State Division of Health, Department of Health and Social Services. (Compiled by Wisconsin Regional Medical Program)

For practical purposes it seems reasonable to accept these figures as the best available estimate of the total number of persons in Wisconsin with diagnosed heart disease in 1970.

Table 2 provides the data base for the second portion of the study and constitutes an estimate of the total number of persons discharged from Wisconsin hospitals annually for treatment of one of 20 separate diagnoses which, by present standards, may at some point require cardiac catheterization or cardiac surgery. The left-hand column identifies the administrative district by number. The body of the table gives the estimated number of discharges per year, by age group for residents of each of the eight administrative districts.

These figures provide the best estimate of the total number of persons admitted to Wisconsin hospitals annually for diagnosis or treatment of heart disease. Figures are derived from an expansion of estimates from the Health Facility Discharge Survey done by the Statistical Services Section of the State Division of Health, Department of Health and Social Services, in fiscal 1968.

As experience with cardiac surgery continues, it is likely that diagnostic methods and their application also will improve. The proportion of those diagnosed versus those hospitalized may change and diagnosis may come earlier in life. Clearly, in the future, some patients may be better treated by means other than surgery, or on the other hand the use of surgery may be greatly expanded. It is beyond the scope and purpose of this article to consider changes that may occur in the future. The best basis for present extrapolations would seem to be to make use of the best information immediately available. In the future the situation will have to be monitored through periodic discharge surveys in order to adjust to changing conditions as they develop.

TABLE 2—*Number of patients with discharge diagnoses related to need for cardiovascular diagnostic facilities or cardiac surgery, by administrative district of residence and by age—Wisconsin: 1968*

Administrative District	Age Group (Years)					
	20–44	45–54	55–64	65–74	75+	Total
1	281	396	799	963	1,004	3,443
2	475	1,324	1,914	2,395	2,391	8,499
3	224	266	408	744	820	2,462
4	222	392	543	974	991	3,932
5	108	224	272	508	538	1,650
6	108	143	326	603	656	1,836
7	168	202	391	668	675	2,103
8	84	131	147	355	420	1,137
Totals	1,670	2,988	4,800	7,210	7,494	24,162
Percent of Totals	7	12	20	30	31	100

SOURCE: Wisconsin 1968 Health Facility Discharge Survey, State Division of Health, Department of Health and Social Services. (Compiled by Wisconsin Regional Medical Program)

TABLE 3—*Percentage of persons, age 20 and over, with heart disease that are admitted to hospitals annually*

Age Group	20–44	45–54	55–65	65–74	75+	Total
Total Heart Disease	23,649	17,075	28,756	40,894	35,830	146,204
Total Hospital Discharge	1,094	2,988	4,800	7,210	7,494	23,586
Percent of Age Group Hospitalized	4.6	17.5	16.7	17.5	21.0	16.1

Table 3 combines information from Tables 1 and 2 to show the estimated rate of hospitalization annually by age groups for persons with heart disease. As would be expected the rate is lowest for the youngest group presented here since nature has already eliminated the very young with severe congenital lesions. It is quite constant through the ages 45 through 74 years and then shows a slight increase in the oldest group aged 74 and over.

Table 4 is a listing of the 20 diagnoses which are included in the area totals of this study as ranked in order of frequency of occurrence. Those causes which are of such low frequency that each produces an annual total of less than 400 cases have been lumped into one group. Together they account for 1,353, or 5.6 percent of the total cases.

The first column of Table 4 is the ICDA number (7th revision). The second column is the title of the diagnosis. The third column lists the estimated total number of discharges annually of Wisconsin residents from Wisconsin hospitals for each listed diagnosis. Those diagnoses which are checked in the fourth column are usually considered to require open heart procedures if they are to be corrected, although there may be some variance of opinion. The fifth column lists the proportion of those patients

TABLE 4—*Annual number of discharges of persons by diagnosis, open or closed heart surgical procedure, and probability of need for surgery—Wisconsin: 1968*

ICDA Number	Title	Total Number of Discharges	Usually an Open Heart Procedure	Percentage Probably Candidates for Surgery at Present	Estimated Number of Candidates for Surgery
420.0	Arteriosclerotic heart disease, as described with or without angina pectoris	7,538	X	50%* Yes	3,769
420.1	Acute coronary occlusion	6,669	X	2%* ? Yes	133
420.3	Other heart disease specified as involving coronary arteries	4,228	X	50%* Yes	2,114
434.1	Congestive heart failure	3,046	X	25%* Yes	761
420.4	Angina pectoris without mention of coronary disease	869	X	50%* Yes	434
420.2	Healed coronary occlusion	459	X	50%* Yes	230
434.2	Left ventricular failure			No (? Cause)	
434.3	Other diseases of the heart			?	
410.0	Diseases of mitral valve, inactive, rheumatic, or unqualified		X	Eventually 90% Yes	
754.3	Interauricular septal defect		X	98% Yes	
754.2	Interventricular septal defect		X	95% Yes	
754.6	Unspecified malformation of heart		?	?	
416.0	Other heart disease specified as rheumatic	1,353	?	Probably Yes	1,353
754.8	Congenital stenosis of pulmonary artery		X	90% Yes	
754.0	Tetralogy of Fallot		X	98% Yes	
754.1	Patent ductus arterioli (Botalli)			99% Yes	
754.7	Coarctation of aorta			95% Yes	
451.0	Dissecting aneurysm not specified as syphilitic			50% Yes	
421.0	Chronic endocarditis not specified as rheumatic		?	No ?	
411.0	Diseases of aortic valve specified as rheumatic		X	50% Yes	
Totals		24,160			8,794

* It is not presently agreed on how many of these subjects should have surgery. Current practice varies from a very high to a very low percentage. The percentage listed is regarded as an educated guess to be modified by further experience.

who would very likely be candidates for surgery once the diagnosis was made.

This information is very significant to the problem of planning for the development of open heart surgery in Wisconsin. Total open heart procedures would be 8,794 for the State as a whole. This would be a maximum as the 14 diagnoses that are grouped to total 1,353 patients include several that are not usually considered to be open heart procedures. This figure of 8,794 also includes a backlog of unknown size. All cases diagnosed would not necessarily require surgery immediately.

The percentages provided in column five of Table 4 are the best educated guess of one individual (G.G.R.) as to the overall proportion, and it would vary widely depending upon the experience and philosophy of the physician, or physicians, whose opinion is sought.

Every case encountered requires an individual decision based on the state of the patient's disease and his general condition, and that decision is influenced by the experience of the referring physician and the cardiac surgical team involved.

Conclusions

Basic information for the use of planning agencies is available and has been presented. It is the best information available at present, and it relates to the current need for cardiovascular diagnostic facilities and cardiac surgery services.

In health as in economics the "need" and the "demand" may differ considerably. It has been pointed out that there are wide differences in the application of surgery within the same diagnosis. Only time and experience will tell which is nearest the truth. Present indications are that the "demand" is developing very slowly. Figure 1 shows that cardiac surgery is currently being done in a minimum of 17 hospitals in Wisconsin.

The 1969 survey conducted by Regional Medical Programs Service showed that only one hospital was exceeding the recommended minimum of four to six open heart cases per week and that a second was approaching the minimum. Currently both are known to be exceeding a level of four cases per week.

The demand for cardiac surgery seems to be developing very slowly in Wisconsin. It is difficult to rationalize the development and maintenance of the present 17 centers in Wisconsin. To comply with national standards reported above, these centers would have to handle a minimum of 3,536 cases per year to meet the minimum requirement of four cases per week. Yet they are far short of that number.

The problem with organizing facilities and teams now to meet the current estimated need, considering the lag in demand, is that equipment and procedures will be out-of-date before they can reach the minimum recommended levels of use. Furthermore if all the present units functioned at an optimal rather than a minimal case load, the estimated need probably could be handled without formation of any additional units. Considering the lag in demand further, it seems possible that the need has been over-estimated.

In this regard we may consider the following possible sources of error. Patients who were admitted and discharged more than once in the period from which the hospital data were collected would have been counted more than once. This would cause the present method to over-estimate the need for surgery. On the other hand many very ill subjects cared for at home or as outpatients are not seen in the data base and would make the estimates too small.

Physicians will not agree on the percentage estimates of those said to require surgery. Anyone who has an opinion on this subject may substitute the percentage figure he prefers and recalculate the data to suit his preference. It is only fair to say that the estimate made will probably not remain a constant in the opinion of any observer and will change as his experience grows.

There are alternative ways of estimating the need for open heart surgery, but for the present this appears to be the simplest and most straight-forward approach. Time and experience may change this belief. Meanwhile if the present article causes others to think about the problem and to devise better ways to collect and analyze data, it will have served a useful purpose.

ACKNOWLEDGMENT: Many persons have contributed to the preparation of this report. Among those who have made the greatest contributions are: Mr. Roy Ragatz, Sigurd E. Sivertson, MD; Paul C. Tracy, MD; Paul C. Nutt, MS; Raymond D. Nashold, PhD; Mrs. Sylvia Kassalow; Josef Preizler, MD; and the members of the ad hoc committee on development of the standards as outlined in the article.

RESOURCE MATERIAL

1. 1970 Special Hospital Services for Cardiovascular Disease Patients: Vol. II, Surgical Service. Health Services and Mental Health Administration (HSM) 71–7020(b).
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4. Report of Subcommittee Re Cardiovascular Diagnostic Facilities. Wisconsin Regional Medical Program (unpublished manuscript), May 1970.
5. Standards for Cardiac Diagnostic and Surgical Centers. American Heart Association, 1965.
6. Report of Inter-Society Commission for Heart Disease Resources: Optimal Resources for Cardiac Surgery, *Circulation* 44:A221-236 (Sept) 1971. □

MARK YOUR CALENDAR √ TUESDAY, SEPTEMBER 19 IN MILWAUKEE

Planning for Primary Prevention of Heart Attacks: A Symposium on Consumer Health Education

GEORGE A. HELLMUTH, MD
Milwaukee, Wisconsin

WE LIVE IN A GROWING and complex society in which planning, use of resources, and coordination are essential if goals are to be attained. The field of health care, because of its important objectives of saving and prolonging healthy and useful lives, is one area where coalition of effort is of the utmost importance. The condition referred to as being healthy is a combination of many interacting forces, including the individual's environment, his reaction to it, his associations, his psychological background, and his ability to accept attitudinal change. Because healthiness is a state of complete physical, mental, and social well-being, it is, by its own definition, of a holistic nature. To care for the health needs of society requires not only the services of the physician but also the nurse, dentist, pharmacist, social scientist, health counselor, therapist, educator, and a host of others.

Together, members of the medical and health professions can work towards providing the optimum in the delivery of health care.

The physician and allied health professional can now cooperate and promote their knowledge in the component of consumer health education, an integral part of total health care. In its advancement of the concept of primary prevention of disease, i.e., before the development of the disease process, it is a major approach to combating the rapid increase in occurrence and distribution of chronic illness. This concept is particularly applicable to preventing the onset of coronary heart disease (CHD) and controlling the further progress of its clinical manifestation—a heart attack.

In a nation where 14 million people have cardiovascular disease and are in need of rehabilitation, where approximately 30% of middle age adults are at major risk of CHD, and where 60% of sudden heart attack cases involving men under 60 years of age outside of the hospital die within one hour of the initial attack, effective implementation of programs directed towards informing and persuading the health consumer citizenship to undertake preventive measures is one of the most crucial aspects of public health care in this century.

While the discipline of health education does not have a fully established body of knowledge and much research is needed in the field, measures can and should be initiated now to prevent many deaths and disabilities. The consumer cannot wait for all the experimental knowledge to be known. His very life is at stake. This is perhaps the country's most vital need, a need that will take much time, effort and money on the part of countless individuals.

Little progress has been made in conveying to the public available health knowledge and establishing a health care delivery system which focuses on disease before the fact. That is to say, although effective medical management of heart attacks has steadily progressed, especially in controlling cardiac arrhythmias and related acute complications through the development of hospital intensive and progressive CHD unit programs, the incidence of CHD is still rising.

If we are to check cardiovascular heart disease, it is crucial that the federal, state and local governments, private agencies, community services, societal institutions, and the medical and allied health professions offer coordinated leadership in the design of newer and more effective methods of communicating with the health consumer and convincing him of the benefits of preventive medicine.

Prevention is the most significant approach to stopping the high incidence of heart attacks. It is well known that risk factors have been identified that contribute significantly to the development of CHD. These include smoking, a diet high in saturated fat and cholesterol, elevated blood lipids, hypertension, obesity, hyperglycemia, sedentary living, psychosocial tensions, and a positive family history of premature (before age 60) heart disease. It must be stressed that amelioration, modification, or elimination of these risk factors in a person decreases his proneness to heart attacks. However, although society is well acquainted with the meaning of the "sick-role" in illness, most individuals are uninformed about the significant role of these predisposing tendencies, e.g., risk factors of CHD. Therefore, applied especially to the major risk factors of premature heart disease (hypertension, diet and elevated blood lipids, smoking) the goals of primary prevention through consumer health education—health promotion and specific protection—should become two of the most important concerns of public health care in this country.

In line with the problem of how to educate the consumer to protect his heart and become knowledgeable about his health and what the medical and health professions can do to assist in this education, a one-day symposium entitled "Primary Prevention of Heart Attack: A Symposium on Consumer Health Education" will be held

From the Cardiac Work Classification Unit, Department of Physiology, Medical College of Wisconsin, and Curative Workshop of Milwaukee. Doctor Hellmuth is Professor of Physiology and Director of the Cardiac Work Classification Unit.

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in Milwaukee September 19. The meeting, which is the first of its kind, will present a body of knowledge to the allied health professions on their part in the promotion of consumer health education, especially in regard to the prevention of heart attacks.

The objectives of the symposium are: (1) to alert the medical and allied health professions and related agencies and health interested individuals to the seriousness of the occurrence and distribution of CHD, (2) to stimulate their participation, prompt their motivation, and educate them in their responsibilities in primary prevention of CHD through consumer health education, and (3) to acquaint them with the concept of high risk factors in heart disease. Underlying these objectives is the belief that the incidence of CHD will not be reduced unless societal institutions and professions realize their role in the individual's approach to a more healthy lifestyle.

Thus, the symposium is a forward step in educating the public in two respects:

(1) It deals with the interdisciplinary role of the medical and health professions in the promotion of consumer health education. When people need help for their health needs, it is their physicians and the others concerned with health—nurses, nutritionists, therapists, clinicians, and psychological and social scientists—that they must learn to consult. Many of these people are not aware of their important role in educating the public while others know of the need. However, because of the serious academic and health professional manpower shortage, there have been problems in the delivery of adequate health care. This delivery is largely dependent upon the consumer, who himself must be involved at all times in the basic planning of health education and services. It is hoped that, from this conference and the book that will issue from it, the allied health professions will be alerted to their responsibilities in helping the consumer to learn all that he can on how to take care of his health.

(2) The symposium will deal with one level of prevention, i.e., the promotion of consumer health education and specific protection—the primary prevention of CHD. This aspect of heart disease will be emphasized as one of the most important of the medical profession's and its auxiliary agencies' essential tasks because the disease has reached epidemic proportions.

The meeting is sponsored by the Milwaukee Area Committee on Employment of the Handicapped (an affiliate of the President's and Governor's Committees on Employment of the Handicapped) in cooperation with the Medical College of Wisconsin, American and Wisconsin Heart Associations, State Medical Society of Wisconsin, and The Medical Society of Milwaukee County.

It will bring together professionals and laymen involved in health program development from official and voluntary agencies, medical and public health organizations, schools, colleges and universities, business, industry, labor, the mass media, and a broad range of specialists, including health educators, physicians, dentists, nurses, pharmacists, nutritionists, social workers, psychologists, teachers, therapists, and rehabilitation and vocational counselors.

The symposium speakers are nationally known authorities in the field of heart disease and consumer education and will discuss the primary prevention of CHD as it relates to their fields. These include Paul D. White, MD, professor emeritus of medicine at Harvard University; Oglesby Paul, MD, former president of the American Heart Association; H. Mildred McIntyre, BSNEd, former chairman of the Council of Cardiovascular Nursing of the American Heart Association; Samuel Fox III, MD, president of the American College of Cardiology; Ogden Johnson, PhD, director of the Division of Nutrition of the U.S. Food and Drug Administration; Godfrey Hochbaum, PhD, professor of health education and behavioral sciences at the University of North Carolina: Robert Laur, PhD, Deputy Administrator for Prevention and Consumer Service, Dept. HEW, Rockville, Md.;

Paul Pugh, BA, vocational counselor with the Seattle (Wash) Cardiac Work Evaluation Unit; Dean George Reedy of the Marquette University College of Journalism and former presidential press secretary; Yolanda Hall, MS, senior nutritionist at the Dept of Community Health and Preventive Medicine, Northwestern University Medical School; C. Arden Miller, MD, professor of maternal and child health at the School of Public Health, University of North Carolina; and Lee Holder, PhD, dean of the College of Community and Allied Health Professions, University of Tennessee.

Charles A. Hoffman, MD, president of the American Medical Association, will be guest speaker at the evening banquet. He will discuss "The Interrelationships Between the Medical Profession and Health Educators in the Delivery of Health Care."

In conclusion, the symposium and book publication hopefully will notify the public of the rising tide of CHD and what the consumer must know in prevention, how to change health habits and attitudes, how to identify, modify, or eliminate high risk factors of CHD, and how to enter the health care system to seek medical assistance. They should, in the main, be instructed by the medical and health professions and health personnel. This symposium is a small effort, but hopefully a meaningful one, in the dual education in and promotion of unified health guidelines among consumers and medical and health practitioners.

But most importantly the thrust of this endeavor is to the physician who must now add one more dimension to his already busy life; namely, greater emphasis and leadership in primary prevention by promoting health education and specific protection in his responsibility to society, his community, and to his patients. This concept is the basis for planning the delivery of high quality care for all. □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

"Innocent human life must be protected"

"NEW PERSPECTIVES in Abortion Reform" printed in WMJ 6/72 was written by an articulate individual who refers to principles yet chooses to ignore the most basic principle upon which the State is founded, "Innocent human life must be protected." In place of this he has substituted a new code, "Anything or anyone who represents a social or economic liability must be eliminated."

Surely an unborn baby residing in a mother has different tissue from his parent. His chromosomes and genes are fixed at conception. While a mother's tonsils are hers alone, her unborn baby has a different blood type, different nervous system, circulatory system, and alimentary canal. He is a different person; given shelter and nourishment he may live to be one hundred. Abortion is a collision of basic rights: The unborn baby's right to life vs. his mother's right to pursue her happiness.

The unborn baby has rights to inherit by will and by intestacy. He may be the beneficiary of a trust. He can sue for injury. He is protected by criminal statutes on parental neglect. His right to life has been given preference by the courts over his parents' right to religious freedom.

To credit abortion for the reduction in numbers of infants dead in New York is the ultimate in reverse logic. Abortion has destroyed millions; whether or not it has ever been given the opportunity to take a breath, the human body is just as dead. He is certainly callous—he who uses semantics and logistics to count as statistics only those humans who have escaped his curette.

This doctor states that someone, somehow, somewhere, is having a good time. It certainly isn't the baby nor is it the unfortunate mother. The only one "having a good time" is the death peddler who profits by this act of violence. Their misery puts money in his pocket. Like the executioner of old, he gets paid well.

"Should women be allowed to have abortions?", he asks. "Women have always obtained abortions," he answers. Born or unborn, in their room or in their womb, women have killed their babies. Because it is to be done does not make it right. The woman's drunk and despicable husband presents far more of a social and economic liability than her unborn child. If the doctor is to solve all of her personal problems through violence, he will need other lethal weapons besides his curette.

One hundred and fifty years ago Dr. Christophe Huffland said, "Once doctors take into their consideration who is to live and who is to die, doctors will have become the most dangerous men in the State." It was Hegel's philosophy that only what is useful is good. Hitler gave doctors in Germany the power over life and death. This was first used to eliminate those felt to have incurable mental disease and later those whose lives were considered a liability because of ethnic or religious reasons. There is no doubt now as then that there are doctors eager to participate in such a program.

What is the danger in this philosophy? It is the concept that there is a life not worth living. If any human life is not worth living, all human life is threatened and the life of each of us loses much of its inherent value. In this decade humans have found it easier to survive in outer space, but more difficult to survive in inner space.

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EDITOR'S NOTE: Enclosed with Doctor Brennan's letter were two articles—one was an editorial entitled, "A New Ethic for Medicine and Society," which appeared in the September 1970 issue of *California Medicine,* the official journal of the California Medical Association; and the other, an article entitled, "Medical Science Under Dictatorship," from the *New England Journal of Medicine,* July 14, 1949 issue. □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Six "Work Week" Sessions for MDs Set in Sept.

What does the possibility of a Wisconsin health care public utility mean for physicians?

Where do physicians fit in Wisconsin Health Care Review, Inc.?

What positions should Wisconsin physicians take on issues before the 1973 Wisconsin Legislature?

In September the State Medical Society's 10th annual Wisconsin Work Week of Health will take vital issues such as these to physicians across the state.

The 1972 Work Week is aimed at updating physicians on three important subjects:

- The Governor's Health Planning and Policy Task Force,
- Wisconsin Health Care Review, Inc., and the
- 1973 legislative program of the State Medical Society.

Sessions on these topics will be held for State Medical Society members from 1:30 to 4:30 in six areas of the state:

Sept. 13 (Wednesday)—State Medical Society headquarters, Madison
Sept. 14 (Thursday)—Milwaukee's Tyrolean Town House, Highway 100
Sept. 20 (Wednesday)—Appleton's Holiday Inn
Sept. 21 (Thursday)—Wausau's Holiday Inn
Sept. 27 (Wednesday)—La Crosse's Midway Motor Lodge
Sept. 28 (Thursday)—Rice Lake's King Edward Motor Inn

All members of the State Medical Society are strongly urged to attend at the most convenient location. Watch for reservation cards coming in the mail soon.

Dr. Bayley to Head Military Service Committee; Dr. Weinshel New Member

Howard G. Bayley, MD, Beaver Dam, is the new chairman of the State Medical Society's Committee on Military Medical Service. As such, Dr. Bayley is chairman of the Wisconsin Volunteer Medical Advisory Committee to the Selective Service System.

Dr. Bayley succeeds F. L. Weston, MD, who has been chairman since the original State medical advisory committees were established over 20 years ago.

In line with changes in the Military Selective Service Act, the Advisory Committee has been reduced from five members to three members. In addition to Dr. Bayley, Committee members are F. B. Henderson, DDS, Stoughton, and George H. Handy, MD, Madison, State Health Officer.

Leo R. Weinshel, MD, Milwaukee, has been recently appointed to the State Medical Society's Committee on Military Medical Service. He succeeds J. M. Sullivan, MD, Milwaukee. The Committee works with the Wisconsin Selective Service on occasions when state physicians are being considered for induction for military service.

According to Assistant Defense Secretary Richard Wilbur, MD, no MDs will be drafted into the armed forces this fiscal year. Dr. Wilbur said the physician supply in the military will be sufficient, as matters now stand, to last through the fiscal year that began July 1. Some 1,600 physicians were drafted in 1971.

"March of Medicine" Radio Series Now Heard in Navajo

The popular "March of Medicine" radio series, featuring H. Kent Tenney, MD, Madison, is now being heard in Navajo as well as English. Scripts for the program are being sent to Navajo radio station in Ramah, NM, where they are read by Navajo announcers who translate as they read.

Dr. Tenney

The New Mexico station learned about "March of Medicine" through WHA, the University of Wisconsin station which broadcasts the program. The fact that Dr. Tenney has some Indian ancestors had nothing to do with it!

"March of Medicine" has been on the air since 1945 and is now carried weekly by 35 Wisconsin radio stations. Dr. Tenney is in his 13th year with the program.

Hospital Ass'n. to Coordinate EMS; 12 MDs on 50-Member Task Force

The 50-member Emergency Medical Service (EMS) Task Force met for the first time June 28. The EMS Task Force is the policy-making body of Wisconsin's Emergency Medical Service Program which was put in motion last month.

The Wisconsin Regional Medical Program received approval in July of a $1.2 million grant to establish an EMS Program for Wisconsin. This would tie together statewide communications networks and establish training programs to meet on-site emergency situations across the state.

Members of the EMS Task Force represent mostly health care providers (including 12 physicians), areawide health planning "B" agencies, and some consumers.

At its first meeting, the EMS Task Force turned over organizational responsibility for the project to the Wisconsin Hospital Association. It also set up a six-member EMS Steering Committee to direct the day-to-day operation of the program, under the chairmanship of David C. Reynolds, the State Medical Society's Director of Scientific Services.

The EMS Task Force assigned duties to begin the project to eight organizations:

* **The Medical Society of Milwaukee County.** Establish and organize an emergency medical service council for the Greater Milwaukee Area. That council will work closely with the Comprehensive Health Planning Area of Southeastern Wisconsin.

(Eight such emergency medical service councils are planned under the EMS program, one to each area served by the eight areawide health planning agencies. These eight councils report to the EMS Task Force. In setting up the Milwaukee council, the Milwaukee Medical Society will work with the Milwaukee Hospital Council, the Wisconsin Chapter of the American College of Surgeons, the Office of Emergency Government, and the University of Wisconsin Medical School.)

* **The University of Wisconsin.** Determine the feasibility, need, and instrumentality for the development of the training and curriculum to provide a two-year program for emergency medical technicians.

* **The Medical College of Wisconsin.** Determine ways and means to improve the effectiveness of urban emergency departments.

* **Employers Insurance of Wausau and the Wisconsin Jaycees.** Develop instructional information to indicate other special action to take when a medical emergency is located, how to activate the system, and how to discriminate between the emergency and the non-emergency.

* **The State Division of Health.** Develop a state plan and provide electronic data processing equipment for input, storage, and retrieval of information gathered utilizing state-operated computers.

* **The State Department of Highway Safety.** Establish universal medical service contact point or points, dispatchers' training and orientation, and centralized information.

* **The Wisconsin Hospital Association.** Provide the EMS program coordination, serve as EMS administrative agent for the Wisconsin Regional Medical Program, and arrange for periodic evaluation of the conduct and resources of the various programs outlined above.

Paul F. Markgren, assistant director of the Wisconsin Hospital Association, is acting as head of the EMS program staff for the months of July and August, pending appointment of a permanent EMS project director. It is anticipated that at the end of the three-year EMS project, there will be no permanent EMS staff and all activity starting during the grant period will be continued by the individual participating organizations, with policy set by the EMS Task Force.

Physician members of this task force include: Robert Cadmus, MD, Milwaukee; Anthony R. Curreri, MD, Madison; Joseph C. Darin, MD, Milwaukee; Jerome DeCosse, MD, Milwaukee; J. D. Farrington, MD, Minocqua; George Handy, MD, Madison; John S. Hirschboeck, MD, Milwaukee; Ben Lawton, MD, Marshfield; Otto T. Mallery, MD, Wausau; Thomas Meyer, MD, Madison; Dale V. Moen, MD, Shell Lake; and John R. Petersen, MD, Milwaukee.

EMS Steering Committee members are: David C. Reynolds, Director of Scientific Services for the State Medical Society, chairman; Drs. George Handy and Ben Lawton; Warren R. Von Ehren, Executive Director of the Wisconsin Hospital Association; Vincent Otis, Acting Director of the Bureau of Comprehensive Health Planning of the State Division of Health; and John Radcliffe, Highway Safety Coordinator of the State Division of Highway Safety Coordination.

Dr. Purtell Appoints Three Physicians to Society Committees

Three presidential appointments to State Medical Society committees were approved by the Council July 29.

De Lore Williams, MD, Milwaukee, chairman of the Ad Hoc Committee on Chiropractic was made an ex officio member of the Commission on Public Policy.

George Berglund, MD, Milwaukee, was appointed to a vacancy on the Commission on Scientific Medicine.

John T. Goswitz, MD, Manitowoc, was appointed to a vacancy on the Committee on Cancer.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1972 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

WHCRI Accepts First Peer Review Contract

Wisconsin Health Care Review, Inc. (WHCRI) has accepted its first peer review contract since formation last December.

The first task of the medical–dental–hospital review corporation involves the medical segment only: an on-site independent medical review of patients in institutions for the mentally retarded at Central Colony, Madison; Northern Colony, Chippewa Falls; and Southern Colony, Union Grove.

The corporation is directed by representatives of the State Medical Society of Wisconsin, the Wisconsin State Dental Society, and the Wisconsin Hospital Association. Provision is made for public representation on the board of directors.

The review project is of patients whose care is financed under Title XIX (Medicaid) of the Social Security Act. The WHCRI physician reviewers head a reviewing team which also includes nurses and social workers.

The State Department of Health and Social Services contracted for the review to comply with new Social Security Administration regulations. These call for an on-site independent medical review of each Medicaid patient prior to the anniversary of the patient's admittance to care. After the current review of all Medicaid patients in the Colonies, it is anticipated that a regular periodic review will be instituted.

Each patient's medical record is reviewed, along with his plan of care, the type of care he receives, and the alternatives to his being in the institution in view of his medical needs.

The medical societies of Chippewa, Dane, and Racine counties where the three Colonies are located have been informed of the reviews and their cooperation has been requested. Extensive pilot studies were made at Central Colony and reviews are now in process at Southern Colony. Reviews are scheduled to start soon at the Chippewa Falls facility.

As a separate but related activity, the Department of Health and Social Services also has asked WHCRI to arrange for the medical review component of the state's nursing home patients whose care is financed by Medicaid. Again, this will be an initial review of all such patients in the state, followed by a periodic review of each patient prior to the anniversary of his admittance to care.

Last February the State Medical Society's Committee on Peer Review was designated to carry out the physician component of WHCRI. At that time the former Advisory Committee on Utilization Review Programs of the Commission on Medical Care Plans became a committee of the State Medical Society's Council. Paul B. Mason, MD, Sheboygan, is its chairman and Owen E. Miller, MD, Waukesha, is its vice-chairman.

Heart Attack Symposium Set

Prevention of heart attacks through better public understanding will be the subject of a one-day symposium to be held September 19 at the Pfister Hotel in Milwaukee. For more information, see pages 18, 19, and 66 of this issue.

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SMS committees *in action*

Schools and Health Services. Division on School Health, June 27, made recommendations to the Work Group on Health Education of the Public of the Governor's Health Planning and Policy Task Force. The recommendations were in response to the Work Group's progress report, "The Role of the Schools in Providing Health Services." (See article on that report in the July GREEN SHEET.)

Examinations for School Bus Drivers. Commission on Safe Transportation, June 16, agreed to react to proposed bus driver physical examination forms suggested for use in Wisconsin.

1973 Annual Meeting. Commission on Scientific Medicine, July 21, authorized one large luncheon program with a speaker on a socioeconomic subject for March 26, the second day of the State Medical Society's annual meeting. This was subsequently approved by the State Medical Society's Council at its July 29 meeting. The one luncheon replaces individual luncheons by scientific sections. The 1973 annual meeting will be held March 25, 26, 27 at Milwaukee's Pfister Hotel.

Health Task Force. Commission on Scientific Medicine, July 21, agreed that four of its members would formulate a presentation to the Governor's Health Planning and Policy Task Force.

In-Depth Teaching Programs. Commission on Scientific Medicine, July 21, announced that during the 1972–73 academic year In-Depth Teaching Programs of the State Medical Society will be held at St. Mary's Hospital Medical Center, Madison, on November 15, December 14, January 17, and February 15. In addition, Neenah, Wausau, and Eau Claire will be the sites for four additional programs. Programs will be presented in each of these cities in October, November, April, and May. This is possible through the State Medical Society's cooperation with the Department of Postgraduate Medical Education of the University of Wisconsin Extension Service.

Cigarette Machines. Committee on Cancer, June 22, agreed that a letter should be sent to the American Hospital Association urging that its Wisconsin members remove cigarette machines from their hospitals. The letter will be signed by both the Committee on Cancer and the Commission on Cancer (State Liaison Fellows) of the American College of Surgeons.

Immunization. Division on Maternal and Child Welfare, July 22, approved a resolution submitted by the Inter-Organizational Committee on Immunization. It resolves that a statewide campaign be initiated to create a favorable atmosphere for immunization programs directed primarily against diphtheria, pertussis, tetanus, and poliomyelitis to protect individuals of all ages. The Division will be notified how the campaign will be implemented.

Prenatal and Infant Information Packet. Division on Maternal and Child Welfare, July 22, encouraged physicians to use the information service for expectant mothers provided by the State Division of Health, Section of Maternal and Child Health. The service is without charge to the patients upon submission of names by the physician.

AMA President Visits Society

The new president of the American Medical Association, C. A. Hoffman, MD, made a stop in Madison June 27, a few days after his inauguration in San Francisco.

He stopped at State Medical Society headquarters prior to addressing a national meeting of the American Society of Professional Business Consultants in Madison.

At a news conference the Huntington, W. Va., urologist spoke on a wide range of subjects, including the possibility of state regulatory systems for private physicians. He said that type of mechanism was acceptable for public utilities, but "when you talk about medicine, then you're interfering with the patient–doctor relationship.

"When a patient goes to a doctor, he is the employer, the doctor is the employee. When a doctor works under another system, there is a danger he will be subservient to it instead of the patient."

Medical Foundations Aired at Dane County Medical Society Meet

Foundations for medical care "are what the physician wants them to be," according to Boyd Thompson executive director of the American Association of Foundations for Medical Care. He spoke and answered questions at a special meeting of the Dane County Medical Society in Madison July 24.

Mr. Thompson is executive director of the San Joaquin Foundation for Medical Care, the first such foundation to be started in the nation. He briefly outlined the San Joaquin Foundation's history since its inception in 1954.

Today, that foundation offers a full range of services. Under medical society sponsorship and control, it conducts care quality review, examines utilization of medical services and facilities, processes and pays claims, and designs coverage for underwriters and groups.

Federal Grant to Help Low Income Families in Marshfield Area HMO

A $566,452 grant has been awarded the Marshfield Clinic Foundation for Medical Research and Education to establish a health maintenance plan of care for low income families in the Marshfield area.

The grant is from the U.S. Division of Health Care Services, Health Services and Mental Health Administration of the Department of Health, Education, and Welfare (HEW).

It will be used to help provide physicians' services through the Greater Marshfield Community Health Plan to families with incomes under $7,000 who are not eligible for Medicare or Medicaid.

The grant will aid in establishing a "Family Health Center," for this purpose.

Families in this program will be expected to make some payments into the plan on a sliding scale following guidelines set by HEW for such experimental health maintenance organizations.

Ben Lawton, MD, Marshfield, who has been working on the project, said that "this new type of coverage will be an essential factor in testing the feasibility of many of the bills now pending in the Congress which relate to health maintenance organizations and health care aspects of welfare reform."

Frederick J. Wenzel, executive director of the Marshfield Clinic Foundation, stated that "this is a crucial first step in a partnership between the federal government and health care delivery systems designed to provide services to all of the citizens of a given geographic area."

Negotiations are scheduled to start soon with Wisconsin Blue Cross and Surgical Care Blue Shield to implement the program in cooperation with St. Joseph's Hospital and the Marshfield Clinic.

Project director for the program will be Russell F. Lewis, MD, medical director of the Marshfield Clinic. The program's medical director will be John H. Mitchell, MD, of the Foundation's research section on Health Care Delivery Services and Financing.

Milw. Medical TV Network Expands

Starting in September the Milwaukee Regional Medical Television Network will expand its programming of live gastrointestinal and metabolic conferences each month in addition to a broad range of taped programs for physicians, nurses, and dieticians.

Ten Milwaukee hospitals and the Medical College of Wisconsin are in the network, a service which includes a phone hookup so that all viewers can ask questions during the live conferences. Monthly broadcast schedules are posted in all member hospitals.

The American Academy of Family Physicians has approved the live conferences for one hour of elective credit per program. George Spuda, the network's acting director, says the new live conference schedule will include a metabolic conference each Tuesday and a gastrointestinal conference the second Thursday of every month.

Mr. Spuda notes that the network is also set up to make video cassettes of its programs. These are available for use in any hospital requesting them. The cassettes are played on individual equipment much like a cassette-type tape recording.

70 Students Participating in Summer Externship Program

The popularity of the summer externship program for first year medical students continues to grow. This summer, the fourth annual program, a total of 70 students from the two Wisconsin medical schools are learning first hand about family practice by living and working with Wisconsin physicians. This is an almost 70% increase in participants from last summer's 47 externs.

Jim Bowman, a 22-year-old University of Wisconsin medical student, is one of 70 summer externs in the state this year. The Oshkosh native is working with Amery physicians to learn first hand about family practice in a small town. (Photo courtesy of AMERY FREE PRESS)

The 10-week "live in" experience involves 47 medical students from the University of Wisconsin and 23 from the Medical College of Wisconsin. Each student receives a $750 fellowship administered by the Charitable, Educational and Scientific Foundation of the State Medical Society. Funds are contributed by WPS–Blue Shield, Surgical Care–Blue Shield, The Wisconsin Rural Rehabilitation Corporation, the Indianhead Chapter of the Wisconsin Academy of Family Physicians, American Family Insurance Company, Wyeth Laboratories, and individual physicians and hospitals (see also CES Foundation contributions on page 68).

The idea for the program came from the Family Medicine Club at the University of Wisconsin in 1968. The program was organized by the Wisconsin Academy of Family Physicians and quickly grew to involve students from the Medical College of Wisconsin.

Health Task Force Recommends Laws to Set Minimum Insurance Standards

According to the Governor's Health Planning and Policy Task Force, new laws are needed to give Wisconsin's insurance commissioner the power to set minimum health insurance standards in the state.

At its July meeting in Milwaukee the Task Force asked for laws aimed at confusing and deceptive insurance policies and practices after Stanley Du Rose, Madison, state insurance commissioner, said he had no authority in this area.

Ben Lawton, MD, Marshfield, vice-chairman of the Task Force, said the problem is not "the legitimate providers of good health insurance." In fact, he said, "the ones that are doing a good job will be held up as models for the others."

He said "certain companies spend more money fighting claims than they pay out in benefits." In addition, he said, some insurance policies are too limited to be of any use to the policyholder. He cited the socalled "dread disease" policy as one example.

Standards recommended by the Task Force include rate regulation as well as others which would make it easier to compare policies when shopping for health insurance.

Standardized, simplified policies is the aim, along with elimination of misleading or confusing provisions and deceptive sales practices.

Want Non-eligibles Covered

Also on the topic of health insurance, the Task Force proposed that those not eligible to buy a health policy because of poor health condition or unemployment be covered under some new mechanism. According to Dr. Lawton, this would more than likely involve the state's private insurers.

Another recommendation by the Task Force was that there be a moratorium on licensing new health professions until the group has had a chance to reexamine the present state licensing system.

The Task Force considered a program to establish health programs for children and possibly adults as well in the state's schools (see July GREEN SHEET). The group asked Gov. Lucey to appoint a committee to determine if this would be feasible.

A proposal on organization of Wisconsin's health planning submitted by the Health Planning Work Group was discussed and the Task Force adopted a proposal that Wisconsin's health planning areas conform as closely as feasible with state administrative districts. The Task Force also said that an ad hoc committee should consider development of a method for long-range planning throughout the state.

Task Force Endorses Legislation

Four bills considered but not adopted by the 1971 Legislature were endorsed by the Task Force. These would: allow employment of physicians on a salaried basis; permit Medicaid recipients to get care from physicians participating in prepaid group plans; permit treatment of venereal disease in minors without parental consent; and provide a forgiveness loan program for medical students.

The State Medical Society supports the VD treatment and the loan program bills. The Society supports greater flexibility in contracting for the administration of Medicaid, but recommends that any mechanism to administer Medicaid under prepaid plans be reviewed on financial and operational grounds by appropriate agencies of the state government, just as is now done for such authorized contractors as Blue Shield and Blue Cross. The Society also asks that any legislation allowing hospitals to employ physicians include amendments to safeguard the interests of the patient and the physician.

Doctors Kept Informed

Officers of state and county medical societies are being kept up to date on the Task Force on a continuing basis. In late July the State Medical Society sent a 100-page book of information on Task Force work to date to State Medical Society councilors and officers, county society presidents, and AMA delegates and alternates. It is planned that as the Task Force's work progresses, the original book will be supplemented by additional information.

One-fifth of Medical Grads to Remain in State for Internship/Residency

Exactly the same number of this year's Wisconsin medical school graduates, 43, will remain in Wisconsin for their internships as stayed in the state last year. This is about one-fifth of the 195 new physicians who received their degrees here in 1972.

The University of Wisconsin Medical School reports that 22 of its 94 graduates will remain and 72 will intern in other states. The Medical College of Wisconsin reports that 21 of its 101 graduates will remain in Wisconsin and 80 will go to other states. Last year, 17 UW graduates and 26 MCW graduates stayed in the state.

Of the 1972 graduates, 13 at the University of Wisconsin chose programs labeled as residency rather than internship; at the Medical College, 5 went directly into residencies. The UW residents were in the fields of psychiatry, internal medicine, general surgery, pathology, and obstetrics–gynecology. MCW residents are in surgery, orthopedic surgery, family practice, and radiology.

For graduates of both schools, the rotating internship proved to be the most popular type. Also in both schools, the straight medicine program was the most popular specialty program.

For UW graduates, University and affiliated programs were the most popular and the Midwest and East were the most popular regions selected for internships. At MCW, internships in the Milwaukee area attracted the most graduating seniors and the West, particularly California, was the most popular region.

At the July 22 dedication of a state historical marker honoring Wisconsin surgeon Dr. A. J. Ochsner were (left to right): William J. Schereck, supervisor, office of local history of the State Historical Society of Wisconsin; Richard Jenks, director, Sauk County Historical Society; L. C. Pomainville, MD, CESF treasurer and State Medical Society historian; M. F. Huth, MD, third district councilor of the State Medical Society; Henry A. Ochsner, Plain, grandnephew of Dr. Ochsner; and Kenyon E. Giese, Wisconsin Representative, Sauk County.

Dr. Ochsner Marker Erected

A state historical marker honoring one of Wisconsin's most outstanding surgeons, Dr. A. J. Ochsner, was dedicated by the State Medical Society July 22 in Baraboo. The marker, in Ochsner Park, was erected by the Society's Charitable, Educational and Scientific Foundation (CESF).

Dr. Ochsner is associated with several discoveries of worldwide importance on such subjects as appendicitis, aseptic surgery, and cancer treatment, and he published extensively on his research. He was head surgeon at Augustana and St. Mary's hospitals in Chicago and taught clinical surgery at the University of Illinois.

With his encouragement, his cousin's son, Alton Ochsner, became one of the country's most outstanding surgeons and the founder of the Ochsner Clinic in New Orleans.

Henry A. Ochsner, Plain, grandnephew of Dr. Ochsner, said at the unveiling ceremony that his uncle's philosophy was "that there was unlimited opportunity to do good, and it was rewarding. To do otherwise was a detriment to all and to be thanked by no one."

Others speaking at the ceremony were: M. F. Huth, MD, third district councilor of the State Medical Society; L. C. Pomainville, MD, Wisconsin Rapids, CESF treasurer and historian of the State Medical Society; Richard Jenks, Baraboo, director of the Sauk County Historical Society; and William J. Schereck, Lodi, supervisor of the Office of Local History of the State Historical Society of Wisconsin.

Dr. Weygandt Heads State Highway Safety Advisory Council

James L. Weygandt, MD, Sheboygan Falls, was elected chairman of the State Advisory Council on Highway Safety at the group's July meeting. Dr. Weygandt is chairman of the State Medical Society's Commission on Safe Transportation.

He succeeds William Redmond, Madison, division of highways, who has held the post for several years. Dr. Weygandt named Mr. Redmond and Rudy Horn, loss control director for Sentry Insurance, Stevens Point, to the council's executive committee.

During the past year Dr. Weygandt was the advisory council's vice-chairman. The new vice-chairman is James O. Peterson, Madison, administrator for the division of motor vehicles. Mrs. Lucile Fessler, Sheboygan, women's highway safety leader, was reelected council secretary.

Last year Dr. Weygandt served on the Governor's highway safety task force. He also is president-elect of the American Association for Automotive Medicine.

The council's executive committee will meet next month with John Radcliffe, Governor Lucey's highway safety coordinator, to map plans for the new year of safety activity, which will include strong emphasis on new legislative recommendations for consideration by the 1973 Legislature.

Incorrect Completion of Medicare Claims Still Causing Delays

About one-third of claims filed for payment in Madison under Medicare Part B (medical insurance) cannot be paid promptly because they are incorrectly completed, reported WPS–Blue Shield, a Medicare fiscal agent in Wisconsin.

Delays most often come because of missing or incorrect information, such as the beneficiary name, health insurance claim number, address, diagnosis, and itemized receipt.

The importance of properly completing Medicare claims and understanding Medicare benefits was stressed during the month of July by the Social Security Administration.

July, the sixth anniversary of Medicare, was designated "Medicare Month" by the Social Security offices serving Wisconsin, Illinois, Indiana. and Minnesota.

SMS Hot Line

THE 2.5% FEE INCREASES allowed by the Price Commission to physicians and other non-institutional health care providers can be accumulated from one year to the next. All or part of that 2.5% can be carried over, provided accelerating costs justify an increase, the Price Commission has ruled. The MD who doesn't raise fees this year could increase them as much as 5% next year.

TYING MEDICAL SOCIETY MEMBERSHIP to mandatory continuing medical education is now the rule of the Pennsylvania Medical Society (PMS). As of July 1, PMS became the first state medical society to require all active and senior active members to qualify for the American Medical Association's Physician's Recognition Award within three years in order to retain their membership.

A RECORD 4,400 PHYSICIANS are now members of the State Medical Society. This figure represents approximately 90 percent of the active physicians in the State of Wisconsin. Membership has been rising steadily over the past decade.

WILLIAM D. JAMES, MD, Oconomowoc, is the new president of the Wisconsin Association of Professions (WAP). Dr. James, who was State Medical Society president during the year 1968-69, succeeds Madison architect Robert P. Torkelson as WAP president. WAP members belong to nine state professional societies, one of which is the State Medical Society. Other professional groups are those for architects, lawyers, educators, pharmacists, engineers, dentists, veterinarians, and certified public accountants.

Milwaukee Included in National Health Survey

About 300 persons aged 1 to 74 years from Milwaukee county will be invited to receive health and nutrition examinations in a study beginning September 15 and ending October 7 in the Milwaukee metropolitan area. The examining program is part of a nationwide survey of young persons and adults conducted by the Health and Nutrition Examination Survey of the U. S. Public Health Service.

The Survey will examine a representative sample of the U. S. population over the next two years, visiting 64 locations throughout the country for this purpose. The Survey will be collecting uniform statistical information on selected chronic disease conditions and on the nutritional status of the population aged 1–74 years. Persons to be examined are selected by scientific sampling techniques and invited to participate in the data-collecting process. Examinations are conducted at the Survey's mobile examination center, which will be set up at a central location.

Each examination team consists of: a general examining physician, dermatologist, ophthalmologist, dentist, nurse, laboratory technician, two health technicians, secretary, three nutritionists, and supporting staff of administrative personnel and interviewers.

All data and information collected from those individuals participating in the Survey are used for statistical purposes only and are strictly confidential. A copy of examination findings, including laboratory findings (hemoglobin, red and white cell counts, cholesterol, iron, vitamin levels, etc.) may be made available to an examinee's personal physician or clinic physician should this be requested and authorized by the examinee. Findings of the examination are not made available to the examinee by the examining staff, but rather through his physician.

Operationally, the Survey is preceded in each area by interviewers from the Bureau of the Census, who visit the selected census tracts for the purpose of identifying the eligible persons and collecting related information. From this list of eligibles, a number of sample persons is selected and later contacted by Health and Nutrition Examination representatives, who explain the Survey, seek authorization for participation, and arrange appointments for the examination and transportation. No charge is made for the examination and transportation provided to and from the mobile examination center.

SECTION OPHTHALMOLOGY

MEDICINA NUSQUAM NON EST — STATE MEDICAL SOCIETY OF WISCONSIN

AUGUST 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WIS. SCHOOL FOR THE VISUALLY HANDICAPPED

Visually handicapped children and youth of the State of Wisconsin are eligible to attend the Wisconsin School for the Visually Handicapped (WSVH) located in Janesville. As an extension of the Department of Public Instruction, the school operates as part of the free public school system of the State, and serves as the focal point for the State in its efforts to provide exemplary and innovative educational programming for Wisconsin's visually impaired children. Open to residents of the State of Wisconsin, the school provides for each pupil free of charge board, lodging, laundry, tuition, books, and other expenses correlated with scholastic activities.

The regular academic courses that are found in all local public school systems are taught in a program that ranges from kindergarten through the twelfth grade. The high school is organized to offer a complete college preparatory program, as well as a general high school program including extensive vocational preparation.

The core of any school is its curriculum and staff. The curriculum at WSVH is divided into five areas. The academic phase of the program has been briefly discussed above. The other four areas are Vocational Education, Music, Physical Education and Recreation, and Personal Management. Each area plays an important part in the development of every student. Each child receives as much training as feasible in each of the aforementioned areas.

The Vocational Education Department provides instruction in home economics, woodworking, general shop, business education, arts and crafts, piano tuning and repair, chair caning and re-seating, electronics, small engine repair, ceramics, lapidary, weaving, basketry, metal arts, plastic arts, and marketing.

Physical Education and Recreation are an essential part of a child's education. It is even more important to the youngster who has a visual handicap. Because of this need, physical education classes, including swimming, are provided for each youngster enrolled in school. Directed recreational activities of all types are offered after school and on weekends.

The instruction in Personal Management is extremely important to both the partially sighted and the blind child. The need for independent travel instruction for the totally blind child is self apparent. The partially sighted pupil faces many problems that are not easily recognized, but still pose problems for him. The successful attainment of complete orientation and the ability to be independently mobile are two of the most important facets in the total education of a visually handicapped student. It is extremely important for every visually handicapped student to be as completely independent as feasible in his travel. All daily living skills necessary for total personal management are emphasized. Total self-management is a goal for every student.

All members of the faculty are professionally trained, and undergo extensive training in the education of visually handicapped children.

Because of the nature of the school, it is necessary that much of the equipment be adapted for use by the visually handicapped enrollee. All items necessary for every area of instruction have been specifically adapted or developed for use by youngsters with limited vision, or for those who are blind.

Because WSVH is primarily a residential school, it is necessary to provide housing for the students. This is done in modern dormitories. The buildings are fully equipped with all modern equipment and possess spacious lounge and recreation areas indoors as well as excellent play areas outdoors. The staff of house parents provides constant supervision and guidance for all students. For those youngsters who do not live close enough to go home every evening, arrangements may be made by their parents for them to be at home for the weekends. This policy is encouraged by the school. Pupils must go home for the Thanksgiving, Christmas, spring, and summer vacations.

The school maintains a Health Center with the services of a registered nurse. The school's physician makes periodic visits to the Health Center and is on call day or night. The school also has the services of an ophthalmologist, who makes regular routine checks of all children.

Special institutes are held at the school each year for parents of preschool-age blind children. Parents are encouraged to bring their children with them for purposes of evaluation and demonstration of techniques and activities valuable to proper growth and development.

Any parent desiring to make application for his youngster to enroll should contact: Superintendent, Wisconsin School for the Visually Handicapped, 1700 West State Street, Janesville, Wisconsin 53545. Referrals also may be made by ophthalmologists, local school systems, public health departments, or other professional sources.—WILLIAM ENGLISH, *Superintendent* □

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COUNCIL MINUTES—State Medical Society of Wisconsin

MILWAUKEE, MAY 7, 1972

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:55 p.m. on Sunday, May 7, 1972, at Holiday Inn Central in Milwaukee.

All voting members were present except Doctor Davenport: Doctors Schrank, Galgano, Huth, Nordby, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Doyle, Williams, Pittelkow, Egan, LaBissoniere, Foley, Schmidt, Meyer, Past President McRoberts, President Behnke, and Speaker Nereim.

Others present: Doctors Bell, Collentine, Galasinski, Hildebrand, Picard, Russell, Dessloch, Carlson, and Kief, AMA delegates and alternates; President-elect Purtell; Vice-speaker Hamlin; Treasurer Weston; Doctors Simenstad, Bernhart, Bein, Biek; Messrs. Thayer, Koenig, Brower, LaBissoniere, Doran, Maroney, Reynolds, Johnson, Brown, Kastner, Gill, Tiffany, Murphy, Kluwin; Neil Sutherland, AMA staff; Mmes. Davenport and Sturlaugson; Miss Pyre; Dan Patrinos, *Milwaukee Sentinel.*

2. Approval of Minutes

On motion of Doctors Dettmann–Rohde, carried, minutes of the February 26–27, 1972, meeting were approved.

3. Edward J. Logan

On motion of Doctor Schmidt, variously seconded, the Council adopted a resolution in tribute and respect to the memory of Edward J. Logan. (Resolution appeared in the May issue, page 36c, GREEN SHEET)

4. Election of Commission on State Departments

By separate motion duly made, seconded and carried, the present chairman, vice-chairman, and division chairmen were reelected.

5. Annual Report of Treasurer

On motion of Doctors Egan–Huth, carried, the annual report of the Treasurer on the Society's General Fund was accepted.

6. Report of Ad Hoc Committee on the Annual Meeting

On motion of Doctors Foley–Rohde, carried, the Council accepted the following recommendations of this committee, except that item four was amended at the suggestion of the Executive Committee:

1. The scientific program and the House of Delegates should convene at the same time of year with the House of Delegates meeting before and, if necessary, after the scientific programs.

2. Separate budgets should be provided for the House of Delegates and the scientific programs.

3. The scientific programs should be limited to two days and follow the format of the 1972 meeting for 1973 and 1974. The 1975 meeting should utilize the facilities of the Sheraton Motor Inn, the Coliseum and offices of the State Medical Society in Madison.

4. The Commission on Scientific Medicine will be expected to submit an annual budget for postgraduate education including annual meeting expenses which will be considered by the Council in relation to the adequacy of dues resources in the future to finance these activities since it is anticipated that technical exhibit income will be entirely phased out by 1975.

5. The Bylaws of the State Medical Society be changed to provide the Commission on Scientific Medicine be composed of nine members, three of whom will be appointed each year for a three-year term, the tenure of any commissioner to be limited to three consecutive terms. In addition, the Medical Editor of the *Wisconsin Medical Journal* and the Deans of the University of Wisconsin Medical School and the Medical College of Wisconsin continue to serve as members.

6. The matter of continuing educational programs be referred to a special committee.

7. The Ad Hoc Committee continue its existence to evaluate the recommendations contained herein.

8. The Wisconsin specialty societies be asked to appoint a representative to attend meetings of the Commission on Scientific Medicine to effect liaison on a continuing basis.

7. Preliminary Report of Ad Hoc Committee on Chiropractic

Doctor Williams reported on the three meetings held thus far and his belief that the committee is very well constituted. He also noted several resolutions relating directly to chiropractic which had been introduced for action by the House of Delegates.

8. Report of Commission on Medical Care Plans

Doctor Dessloch referred to the Commission's report in the delegates handbook, as well as Commission reports to the Council on two subjects which were before the House of Delegates last year: (a) benefits for alcoholism, and (b) procedure coding systems. These were accepted and forwarded to the House.

In addition, the Commission requested that the Council authorize an increase in the number of public representatives, up to one-third of the Commission membership. On motion of Doctors Schrank–Lewis, carried, this authority was granted by the Council.

9. Proposed Statement to AMA Council on Long-Range Planning and Development

Doctor Galasinski reported suggestions of the AMA delegation in reference to a draft statement to be presented in behalf of the Society at the May 10 hearing by the AMA Council on Long-Range Planning and Development.

On motion of Doctors Mauthe–Schmidt, carried, the statement was accepted with certain editing and deletion of item six of the draft, for presentation by Chairman Nordby.

10. Report of Special Committee on Shortage of Physicians

The Council received a progress report prepared by Doctor Mortensen which indicated that the committee intends to concentrate on offering constructive criticism and suggestions to Task Force work groups on subjects within its purview. The committee is encouraged by reports indicating that the two medical schools apparently are on the verge of a major expansion in the number of freshman students to be admitted. The committee specifically wished to compliment the UW Medical School in the development of its family practice residency program, to encourage its continuation and expansion into other areas of the state, and also encourage the Medical College of Wisconsin to continue to seek the establishment of such a program.

On motion of Doctors Schrank–Rohde, carried, the Council commended the committee, urged that it seek to establish more internships and residencies throughout the state, and encouraged it to bring further recommendations to the Council.

11. Report of Committee on Economic Medicine

Doctor Schmidt presented the committee's report in two sections: the first on programs currently sponsored by the Society such as group life, disability income protection, and others, with the recommendation that through the GREEN SHEET and in other ways more detailed information about these programs be reported to the membership on a periodic basis.

In reference to professional liability insurance, the committee concluded that for reasons stated in the report "the best interests of the total membership would not be best served, at this time, by the sponsorship of or an attempt to implement any one program of professional liability insurance." In this regard the committee recommended:

1. Continuing and expanded contacts with all elements of the professional liability insurance industry as they relate to medical practice including the services of allied personnel for whom physicians are held responsible. This would include an offer of the availability of the committee to meet more frequently with insurance carrier representatives to discuss and hopefully resolve questions as they arise in underwriting and claims administration to the end that adequate insurance markets may be retained and perhaps expanded.
2. Exploration, in cooperation with other agencies of the Society, of educational programs designed to reduce liability claims and losses together with the implementation on a coordinated basis of those programs deemed to have merit.
3. A study of the feasibility of proposing legislative reforms which might alleviate certain problem areas. Such studies also to be coordinated with other agencies of the Society.

On motion of Doctors Egan–Edwards, carried, the report of the committee was accepted by the Council and forwarded to the House of Delegates.

On motion of Doctors McRoberts–Foley, carried, the Council authorized continuation of the professional liability consultation service by Mr. Kluwin for another year.

12. Report of Planning Committee

The Planning Committee proposed two Constitutional and one Bylaw amendment in the following sections:

(a) Article II of the Constitution entitled "Purpose"
(b) Article IX of the Constitution entitled "Officers" relating to the election of councilors
(c) Chapter VII, Sec. 2, of the Bylaws relating to membership of the Commission on Scientific Medicine

By separate motion these amendments were forwarded to the House with the Council's recommendation. See House action, May 1972 *Wisconsin Medical Journal* GREEN SHEET, pages 36a and b.

In addition, Doctor Manz read proposed Bylaw amendments to combine all classes of membership and all references to dues for the various categories in Chapter I, and also referred to a proposed restatement of duties of the Commission on Scientific Medicine. The chairman asked that these recommendations be presented to the Council in writing at a later time.

13. Report of Finance Committee

Doctor Dettmann reported on the committee's periodic review of expenses in relation to the budget, noting that the contingency fund has been reduced by reason of a rent increase due to reallocation of payroll for SMS-assigned employees.

Three items were reported for action:

(a) Health Insurance for Totally and Permanently Disabled Employees

On motion of Doctors Dettmann–Mauthe, carried, the Council approved the policy of terminating totally and permanently disabled employees at such time as they become eligible for disability benefits under the Social Security Act, and also discontinue Society payment for health insurance which would continue to be available through a conversion contract on a direct payment basis, as would group life insurance under the waiver of premium clause.

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(b) Health Insurance for Retirees

The committee recommended reconsideration of earlier Council action to continue health insurance payments for retired employees and their spouses in view of the potentially burdensome cost for which there is no reserve.

On motion of Doctors Dettmann–Heinen, carried, the Council approved discontinuation of this policy, except for the three retirees who benefit from the prior action.

(c) Commission on Health and Natural Resources Fiscal Note

The committee considered a request of this Commission in its annual report to the Council and House of Delegates for a $500 contribution from the Society toward a study by a UW graduate student of testing swimming water, sewer discharges into Lake Mendota, and infections found in children in a Madison area which houses principally faculty, students and their families. The committee did not believe dues income should be used for such a study and recommended the request be referred to the CES Foundation.

On motion of Doctor Foley, seconded and carried, the report of the Finance Committee was accepted.

14. Woman's Auxiliary

Mrs. MacMillan, outgoing president of the Auxiliary, asked councilors to impress upon local auxiliaries the need for physicians' wives to join the auxiliary in preference to hospital volunteer programs, as "we have great things to carry out."

15. Report of Executive Committee

(a) Wisconsin Regional Medical Program, Inc.

Doctor McRoberts has consented to serve another year on the board of directors of WRMP to provide continuity to the Society's participation in the direction of its activities.

(b) Wisconsin State Medical Assistants Society

Drs. R. M. Baldwin, Beloit; Rodrigo A. Munoz, Sheboygan; and W. D. James, Oconomowoc, were redesignated as physician advisors to the Medical Assistants Society.

(c) Legislative Activity

On motion of Doctors Schrank–Heinen, carried, the Council approved the recommendation of the Executive Committee that a full-time staff person be employed to conduct the day to day lobbying services currently provided by legal counsel and to coordinate communications between the State Society's Commission on Public Policy and the county society public policy committees.

(d) 1973 Annual Meeting Dates

It has previously been determined that the annual meeting will be held in Milwaukee in 1973 and 1974. After hearing a report on the competition from other organizations for hotel space, the committee recommended a March meeting in 1973—March 25–26–27. Available dates in May would be in direct conflict with the Minnesota State Medical Association.

On motion of Doctors Dettmann–Rohde, carried, the Council approved this recommendation utilizing the Pfister Hotel and the Marc Plaza as necessary.

(e) Proposed Legislation on Control of X-ray

The committee reported for information that it had reviewed a preliminary draft of a proposed law prepared for the Council on Health which would require state licensure of technicians who operate x-ray equipment of any type in the offices of physicians, dentists, podiatrists, chiropractors, and similarly licensed health practitioners. The committee believed that the bill as drafted unnecessarily duplicates voluntary certification for x-ray techni-

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cians and fails to remedy problems in the use of x-ray by chiropractors themselves. It has requested that the entire matter be discussed in detail with the Radiology Section and Society so that appropriate comment can be made to the Council on Health expressing the views of medicine with regard to this proposal.

On motion of Doctor Mauthe, seconded and carried, the report of the Executive Committee was accepted.

16. Special Report by the Chairman of the Commission on Scientific Medicine

The Council received a report by Doctor Derus suggesting rephrasing of the Bylaws to more clearly indicate the responsibilities of the Commission, and also elaborating upon its role in postgraduate and continuing education, accreditation and self-improvement programs.

On motion of Doctors Foley–Mauthe, carried, the report was received for information at this time. (Report appears in June issue, page 29, GREEN SHEET)

17. Report of Committee on Peer Review

The activity report of this committee was forwarded to the House of Delegates on motion of Doctors Lewis–Dettmann, carried, with the recommendation that all county societies give it their full endorsement and support.

18. Proposed Nursing Home Survey Program

As a result of his experience in participating in a survey of nursing homes conducted by the Senate Committee on Health and Social Services, Doctor Custer of Marshfield proposed through Councilor Lewis a resolution to the end that the State Medical Society establish a program for the survey and evaluation of patient care and health maintenance in the state's nursing homes, convalescent centers, and extended care facilities, and that the findings and recommendations be known to the Society and other pertinent agencies.

In discussion it was generally agreed that the intent of such a resolution will be carried forth through the Committee on Peer Review and Wisconsin Health Care Review, Inc.

19. Councilor District Reports

As required in the Bylaws, councilors present reported on conditions in their districts. There were no problems reported requiring the attention of the Council.

20. Annual Report on Conflict of Interest Compliance

Mr. Thayer reported that all councilors, officers, and members of the Commission on Medical Care Plans had filed certificates as required, and that three individuals had indicated situations which might possibly present a conflict of interest under certain circumstances. The chairman stated that a ruling would be made at the time of discussion or vote on a motion involving an area of possible conflict.

The secretary also reminded councilors and officers that they are required to report "any future situation, activity or investment concerning which a possible conflict of interest might arise."

21. Appointment to Commission on Medical Care Plans

On motion of Doctors Mauthe–Smejkal, carried, the Council approved the appointment by the Council chairman of David J. Ottensmeyer, MD, Marshfield, to the Commission on Medical Care Plans.

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22. Secretary Certified as Registered Agent for the State Medical Society

On motion of Doctors Nereim–Rohde, carried, the Council certified Mr. Earl R. Thayer as the registered agent for the State Medical Society of Wisconsin.

23. Travel Accident Policy

Mr. Thayer reported that the Finance Committee felt that consideration should be given to increasing the accidental death benefit, particularly in event a death should occur while traveling on Society's business. The present benefit for covered physicians is $50,000, not limited to traveling for the Society.

This was referred to the Committee on Economic Medicine on motion of Doctors Nereim–Heinen, carried.

24. Committee of Eight Status Report

This was made in executive session.

25. Adjournment

The meeting adjourned at 5:10 p.m.

EARL R. THAYER
Secretary

Approved: July 29, 1972
EUGENE J. NORDBY, MD
Chairman

□

COUNCIL MINUTES—State Medical Society of Wisconsin

MILWAUKEE, MAY 10, 1972

1. Call to Order and Roll Call

The meeting was called to order at 10:10 a.m. on Wednesday, May 10, 1972, at Holiday Inn Central in Milwaukee.

Voting members present: Doctors Olsman, Nordby, Huth, Edwards, Smejkal, Mauthe, Dettmann, Rohde, Heinen, Manz, Doyle, T. J. Foley, Schmidt, Egan, Williams, Pittelkow, LaBissoniere, Mayer; Past President Behnke, President Purtell, and Speaker Nereim.

Others present: President-elect Derus; Vice-speaker Nereim; Treasurer Weston; Past President McRoberts; Doctor Biek; Messrs. Thayer, Koenig, Doran, Maroney, Johnson, Kluwin, Gill; Mrs. Anderson; Miss Pyre.

Guests: Raymond T. Holden, MD, Washington, D.C.; James H. Gosman, MD, and Mr. James Waggener, Indianapolis, President-elect and Executive Secretary of the Indiana State Medical Association.

2. Oath of Office

Doctor Nordby administered the oath of office to President-elect Derus and Doctor Olsman, second district councilor.

He then presented framed certificates of election to councilors and officers.

3. Council Elections

By separate motion duly made, seconded and carried, the following were nominated and unanimously reelected:

(a) CHAIRMAN OF THE COUNCIL: E. J. Nordby, MD
(b) VICE-CHAIRMAN OF THE COUNCIL: J. E. Dettmann, MD
(c) TREASURER OF THE SOCIETY: F. L. Weston, MD
(d) ASSISTANT TREASURERS SERVING THE SOCIETY, WPS, and SMS REALTY CORPORATION: H. Kent Tenney, MD, A. A. Quisling, MD, J. T. Sprague, MD, R. A. Sievert, MD, and N. A. Hill, MD
(e) MEDICAL EDITOR OF THE *Wisconsin Medical Journal* (two-year term): Victor S. Falk, MD
(f) EDITORIAL DIRECTOR OF THE *Wisconsin Medical Journal:* Raymond Headlee, MD

4. Special Assessment

The Council advised the secretary that the special assessment should be billed to all classes of members, regardless of dues-paying status, except life members who are specifically exempt from dues *and* assessments; and further that it would consider individually any refusals to pay the assessment which would jeopardize membership continuation since it is a mandatory assessment.

5. 1974 Annual Meeting Dates

The Council agreed that the 1974 meeting should also be scheduled in March: Sunday–Tuesday, March 24–26, where the best arrangements can be made in Milwaukee.

6. Edwin E. Bryant, Nelson Muffler Corporation, Stoughton

On motion of Doctors Behnke–Schmidt, carried, the Council adopted a resolution honoring the memory of Mr. Bryant, former member of the Commission on Medical Care Plans and trustee of the Charitable, Educational and Scientific Foundation. (Resolution appeared in the May issue, page 36c, GREEN SHEET)

7. Remarks by Visiting Officers

The Council heard comments from Doctor Gosman, President-elect of the Indiana State Medical Association, and from Doctor Holden, member of the Board of Trustees of the American Medical Association.

8. Council Meeting Schedule

The chairman announced the following Council meeting dates on Saturdays, to continue on Sunday mornings to the extent necessary:

July 29–30
November 11–12
February 10–11
March 24 preceding the 1973 annual meeting

9. Adjournment

The meeting adjourned at 11:10 a.m.

EARL R. THAYER
Secretary

Approved: July 29, 1972
EUGENE J. NORDBY, MD
Chairman

□

NEWS HIGHLIGHTS

Wisconsin Neurological Society

At the Wisconsin Neurological Society's Spring Meeting June 16–17 at the Pioneer Inn in Oshkosh the following officers were elected: president—Harold E. Booker, MD, Madison; president-elect—Keith C. Bogart, MD,* La Crosse; vice-president—Paul R. Dyken, MD,* Milwaukee; secretary–treasurer—Gastone G. Celesia, MD,* Madison; councilors—Francis M. Forster, MD,* Madison; Francis Kruse, MD,* Marshfield; and Philip T. White, MD,* Milwaukee.

Guest speaker for the meeting was Dr. Mark L. Dyken, chairman and professor of neurology at the Medical School of Indiana University. He spoke on "Changes in Mean Arterial Pressure Following Internal Carotid Ligation." The scientific session consisted of nine papers presented by members and guests of the society.

New Pediatric Clinic at University Hospitals

A new pediatric clinic designed to meet the special needs of children with eye problems opened in June at the children's units of University Hospitals, Madison. Head of the new clinic is Thomas D. France, MD,* a pediatric ophthalmologist. He said the clinic differs from an adult eye clinic in that special techniques are necessary to examine the eyes of infants and children. The clinic sees children with such eye problems as congenital cataracts, congenital glaucoma, impaired vision as a result of accidents or other trauma, and eye problems caused by other diseases of the body. Children as young as three weeks can be examined and surgery can be performed on six-month-old infants, Doctor France noted. Patients can be referred to the clinic by private physicians or other pediatric specialty clinics, or parents can make appointments for their children.

St. Michael's Family Practice Residents Honored

The first two graduates of Milwaukee's St. Michael Hospital's new Family Practice Residency were honored at a residents' dinner June 8. Poderoso Prado, MD and Linda G. Dulay, MD completed their third year of training in the St. Michael Family Care Center. Three second-year and 12 first-year residents were also honored. Benjamin T. Ulep, MD was selected as the outstanding first-year resident.

Edward J. Logan Intensive Care Center, Milwaukee

On July 8 in Milwaukee the Edward J. Logan Intensive Care Center was opened at Milwaukee Children's Hospital. The 21-bed unit serves children primarily from southeastern Wisconsin but also draws patients from the north and west, it was reported. The new unit has been designed to give maximum medical and nursing care to children, from newborns to age 16, in the areas of surgery, cardiac disease, metabolic problems, and poisonings. But it will not duplicate services offered by the neonatal unit at Milwaukee County General Hospital or St. Mary's Burn Center; rather, it will serve as an adjunct to those facilities.

New VA Drug Treatment Center at Wood

The Veterans Administration Hospital at Wood is opening one of 12 new VA drug treatment centers being established across the nation by the VA.

PHYSICIAN BRIEFS

Raymond R. Watson, MD*

. . . Milwaukee, recently was elected president-elect of the medical staff of St. Joseph's Hospital in Milwaukee. He has been a member of the medical staff of St. Joseph's since 1956. He is a graduate of the University of Wisconsin Medical School and is an associate clinical professor of the Medical College of Wisconsin.

Paul W. Phillips, MD*

. . . La Crosse, recently was elected president of the Wisconsin Orthopedic Society. He is a past president of the St. Francis Hospital medical staff and has been associated with the La Crosse Clinic since 1949. Stephen L. Haug, MD,* La Crosse, was elected secretary.

R. Simani, MD

. . . formerly of Oak Park, Ill., recently became associated with the Roche-A-Cri Clinic and the Adams County Memorial Hospital, Friendship. His specialty training in general surgery was taken in the Washington University Affiliated Hospitals in St. Louis, Mo.

N. O. Calloway, MD*

. . . Madison, chairman of the clinical section of the Gerontology Society, recently returned from attending a seminar at the International Congress of Gerontology at Kiev in the Soviet Union.

Stanley W. Hollenbeck, MD*

. . . Elm Grove, recently was appointed the medical director of Home for Aged Lutherans, Wauwatosa. Doctor Hollenbeck is on the medical staff of the Evangelical Deaconess Hospital and serves on its board of directors. He also is a member of The Medical Society of Milwaukee County's committee on nursing homes and the aging.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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PHYSICIAN BRIEFS . . .

Edwin R. Larkin, MD

. . . Madison, recently was appointed assistant state health officer for Wisconsin. He fills a vacancy created when George Handy, MD* became state health officer in February 1971. Doctor Larkin was formerly acting director of the State Division of Health's Bureau of Local Health Services and Program Planning. He is graduate of the University of Wisconsin Medical School.

Michael J. Rietbrock, MD

. . . Oconomowoc, recently became associated with the Wilkinson Clinic. He graduated from the University of Minnesota Medical School in 1968 and served his internship and residency in the West Virginia University Hospital. Doctor Rietbrock recently completed a fellowship in cardiovascular disease at the West Virginia University Hospital.

Susan M. Knutson, MD

. . . Eau Claire, recently joined the medical staff of the Midelfort Clinic. She is a graduate of Temple University Medical School and served her internship in pediatrics at University Hospital, University of Michigan. Her residency was taken at St. Christopher's Hospital for Children in Philadelphia.

John W. Bunke, MD*

. . . Waukesha, recently was reelected president of the American Cancer Society—Waukesha Unit.

Henry J. Schwartz, MD

. . . Minocqua, became associated with Lakeland Medical Associates, Inc. on July 10. Doctor Schwartz graduated from the University of Wisconsin Medical School and served as a medical officer in the United States Navy. He recently completed a residency at The Medical College of Wisconsin affiliated hospitals and assisted in emergency care in the Department of Hyperbaric Medicine at St. Luke's Hospital, Milwaukee.

State Provides Funds to Racine Sickle Cell Program

The Division of Health, Wisconsin Department of Health and Social Services, has agreed to provide the Racine City Health Department with up to $5,000 toward a citywide screening program for sickle cell anemia and the sickle cell trait among persons who are black or of black ancestry. In particular, the program will emphasize outreach contact with about 200 families not yet notified, the Division stated.

Services to be rendered by the city include educational materials and aid in providing transportation when necessary to the 200 families, continued screening and notification services, and arrangements for counseling and referral of those with positive tests as indicated.

The funds for this particular program will come from the Division's Federal formula grant under Public Law 90–248—Social Security Amendments of 1967, Title V, Maternal and Child Health Services.

Services will be rendered in compliance with Title VI of the 1964 Civil Rights Act.

Verona Family Practice Clinic Opens

A new medical clinic, Verona Family Practice Clinic, was opened in July as a result of the Verona community having been selected by the Family Practice Program of the University of Wisconsin Center for Health Sciences as the location for its model rural clinic.

Two family physicians are staffing the clinic: MDs Richard B. Caldwell and Richard D. Larson. Doctor Caldwell is a clinical assistant professor of family medicine at the UW Medical School, Madison. Prior to his appointment Doctor Caldwell was in private practice for four years in Marion, Ind. Doctor Larson is a third-year family practice resident. A native of Minnesota, he earned his MD at the UW–Madison.

Wisconsin Heart Allocates Funds for CV Research

Forty-five Wisconsin scientists have been awarded funds totaling more than a quarter of a million dollars for heart and circulatory research in the coming year by the Wisconsin Heart Association (WHA), John H. Morledge, MD,* WHA president, announced recently.

The $280,991 goes to 41 established researchers and 4 fellowship recipients. They will conduct their studies during the fiscal year July 1, 1972 through June 30, 1973 at four Wisconsin institutions: Medical College of Wisconsin, Milwaukee; University of Wisconsin–Madison; Marshfield Clinic Foundation, Marshfield; and University of Wisconsin–Stevens Point.

State Medical Society members receiving specific grants and their amounts are: John P. Kampine, MD,* Medical College of Wisconsin, "Effect of General Anesthetics on Responses to Acute Hemorrhage," $4,720; Luis B. Curet, MD,* University of Wisconsin–Madison, "The Effect of Exercise on Stroke Volume, Cerebral, Myoendometrial and Placental Blood Flow," $4,300; George G. Rowe, MD,* UW–Madison, "Effects of Aortic Insufficiency on Coronary Blood Flow," $4,622; Jack M. Schneider, MD,* UW–Madison, "Drug Effect(s) on Utero Placental Insufficiency," $5,290; and Phiroze L. Hansotia, MD,* Marshfield Clinic Foundation, "A Study of Cardiac Arrhythmias in Sleep," $2,640.

Thomas E. Henney, MD*

. . . Portage, recently was elected chief of staff of Divine Savior Hospital in Portage. MDs Thomas S. Westcott,* Pardeeville, and Stewart F. Taylor,* Portage, were elected vice-president and secretary–treasurer, respectively.

Chesley P. Erwin, MD*

. . . Elm Grove, recently was named acting medical examiner of Milwaukee County. Doctor Erwin is associate professor of pathology at The Medical College of Wisconsin and staff pathologist at Milwaukee County General Hospital. He replaces Helen C. Young, MD* who resigned.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1972

11 Dane County Medical Society Board of Trustees

19 In-Depth Program Planning Committee

20 Executive Committee and Board of Directors, Wisconsin Association of Professions

20 Executive Committee, SMS Commission on Medical Care Plans

21 SMS Commission on Scientific Medicine

22 SMS Division on Child and Maternal Welfare

22 SMS Maternal Mortality Study Committee

24 Dane County Medical Society

25 Board Exams for Professional Nurses

26 Board Exams for Professional Nurses

27 Executive Committee, SMS Commission on Public Policy

28 Executive Committee of SMS Council

29 SMS Council

29 SMS Council's Planning Committee, Finance Committee, Committee on Economic Medicine, and AMA Delegates and Alternates' Caucus

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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NEWS HIGHLIGHTS . . .

Specialized Center for Research of Lung Disease

A specialized center for research of lung disease will be established at the Marshfield Clinic Foundation for Medical Research and Education. In making the announcement, Senator Gaylord Nelson said the Marshfield project will be funded by a five-year $992,252 grant from the National Heart–Lung Institute, Washington, D.C. The Marshfield Clinic Foundation's first year award is $198,021.

Frederick J. Wenzel, Foundation executive director, said that studies to be conducted under the program will deal with patients with a known hypersensitivity disease of the lung, or with suspected hypersensitivity. An indepth investigation of the basic mechanisms and organisms involved in the development of such lung diseases also will be made.

Mr. Wenzel said "the new funding will enable the Foundation to be part of a larger Center for Research which will include Marshfield, the Medical College of Wisconsin at Milwaukee, and the University of Wisconsin in Madison." Dean A. Emanuel, MD,* long associated with farmer's lung disease studies, is the principal investigator of the Marshfield program.

The entire Wisconsin Center program will be headed by Jordan Fink, MD* of the Medical College of Wisconsin, and an advisory committee of Doctor Emanuel, Mr. Wenzel, Joseph Barboriak, PhD, Milwaukee, and MDs John Rankin and Charles Reed,* University of Wisconsin–Madison.

Cancer Research Grants Awarded

Grants totaling $18,005 recently were approved by the board of directors of the Milwaukee Division of the American Cancer Society. Recipients are Frank E. Frerman, PhD, assistant professor, department of microbiology, Medical College of Wisconsin, $2,890; Roland A. Pattillo, MD,* associate professor and director, cancer research and reproductive biology laboratory, gynecology and obstetrics, Medical College of Wisconsin, $3,115; and Glenn E. Rodey, MD, director, immunology division, department of research, Milwaukee Blood Center, Inc., $12,000.

National Ski Patrol Met in July in Madison

The National Ski Patrol's annual midsummer conference was held July 22–23 in Madison. Eight UW Medical School faculty members led discussions of topics ranging from the nervous system to thermal injuries and bites. Chairman of the conference was Andrew A. McBeath, MD* who was joined by MDs Robert L. Beilman;* William Rock;* Claude Taylor, Jr.;* James C. Tibbetts;* Paul A. Vastola, Jr.;* Robert Watson; and Frank Wolf.

UW Hospitals Parking Improvement

Relief appears in sight for the long-standing patient and visitor parking problem at University of Wisconsin Hospitals, according to Superintendent James W. Varnum. A series of changes begun in June will immediately simplify their parking and by September more than double the space available for patient and visitor cars. Supt. Varnum indicated that one reason for the expansion is to take care of parking demands from University Hospitals' ever increasing outpatient clinic volume. Emergency room patients will continue to receive immediate free parking near that facility in the rear of the Hospitals, Mr. Varnum said.

Wisconsin Surgical Society Fall Meeting

The Fall Meeting of the Wisconsin Surgical Society will be held September 15 and 16 at the Maxwelton Bracs (Door County). The program is under the direction of Leonard W. Worman, MD* of Milwaukee. Residents of medical schools and of teaching hospitals throughout the State are expected to present papers. Further particulars may be obtained by writing: P. Richard Sholl, MD,* Secretary-treasurer, Wisconsin Surgical Society, P. O. Box 551, Janesville, Wis. 53545.

Wisconsin Neurological Society to Meet in November

Members of the Wisconsin Neurological Society will meet in Wisconsin Dells November 10 and 11. Guest speaker will be Doctor Alpers.

Wisconsin Allergy Society Elects Officers

At a recent meeting of the Wisconsin Allergy Society the following officers were elected: president—Jordan N. Fink, MD,* Milwaukee; president-elect—John Oullette, MD,* Madison; and secretary-treasurer—S. Roger Hirsch, MD,* Milwaukee.

American College of Physicians Admits New Members

Three Wisconsin physicians were among 179 physicians who recently were admitted to membership in the American College of Physicians. They are: Marvin A. Perer, MD of Madison and James M. Cerletty, MD and Louis F. Jermain, MD* of Milwaukee.

Wisconsin Nurses Association Annual Convention

"Nursing Practice—the Challenge of Change" is the theme for the annual convention of the Wisconsin Nurses Association, to be held October 4–7 at the Marc Plaza Hotel, Milwaukee.

Wisconsin Governor Patrick J. Lucey will address the general session at 10:45 a.m. Friday, October 6, on "The Governor's Health Planning and Policy Task Force—Report and Recommendations."

At a general session Thursday afternoon a clinical nurse specialist, a physician's assistant, a head nurse and a staff nurse will talk about changes in their roles and relationships in the acute care setting.

At the same time a group of nurses, including a pediatric nurse associate with a city health department; a nurse consultant with a neighborhood health center; a public health nurse employed by a county health department, and a participant in a nurse–physician team project will be discussing "Ambulatory Care Settings: Emerging Roles of the Nurse."

Operating room nurses will follow the WNA Convention with their meeting Saturday, October 7, at the Ramada Inn, 633 West Michigan Street, Milwaukee.

All Wisconsin registered nurses, regardless of whether they are WNA members, are invited to attend the convention. Information may be obtained by writing WNA headquarters, 161 West Wisconsin Avenue, Milwaukee 53203 or by calling 414/272–3670. □

Robert I. Reichle, MD*

. . . Mequon, recently became assistant director of Northwestern Mutual Life Insurance Co., Milwaukee. Doctor Reichle, a graduate of Ohio State University School of Medicine, served his internship at St. Luke's Hospital, Duluth, Minn. Prior to joining the medical staff of Northwestern Mutual Life Insurance. Co., he had been in private practice in Clintonville and Appleton.

Alwin E. Schultz, MD*

. . . Madison, recently was featured in "Know Your Madisonian" in the *Wisconsin State Journal.* A 1948 graduate from the University of Wisconsin Medical School, he taught part-time at the University and worked in the field of gynecologic cancer. Only recently he chose to devote full-time to his practice rather than taking a full-time university position.

Harvey L. Barash, MD

. . . Madison, recently joined the Jackson Clinic staff in the Department of Orthopedic Surgery. Doctor Barash graduated from the Albert Einstein College of Medicine, New York in 1965 and served his internship at Rush Presbyterian–St. Luke's Medical Center. His residency in orthopedic surgery was taken at the University of Illinois Research and Educational Hospitals in Chicago, and he then served two years in military service at the United States Army Hospital, Fort Campbell, Ky.

Ralph V. Landis, MD*

. . . Appleton, long time university physician at Lawrence University, will have the health center at Lawrence dedicated in his honor in October. Doctor Landis began his association with Lawrence in 1925 and has served as team physician in addition to student health needs. He also has maintained a medical practice in Appleton since coming to the city in 1925. □

OBITUARIES

Francis L. O'Keefe, MD, 66, Delavan, died May 14, 1972, in Delavan.

Born on Oct. 27, 1905, in Voss, North Dakota, Doctor O'Keefe graduated from Rush Medical School, Chicago, in 1938. He had been practicing in Delavan since 1940 except for the period from 1943–46 when he served in the United States Navy during World War II.

He was a member of the Walworth County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; two daughters, Mrs. Dipak (Susan) Roy, Westmont, Ill., and Stephanie, at home; and two sons, Timothy and Kim, at home.

Arthur C. Stehr, MD, 67, Madison, died May 22, 1972, in Madison.

Born on Mar. 24, 1905, in Madison, he graduated from the University of Wisconsin Medical School in 1931 and served his internship at Madison General Hospital. Doctor Stehr was on the surgical staff of Madison General Hospital and was on the hospital executive board until retiring 15 years ago. He was a former vice-president of the Dane County Medical Society.

He also was a member of the State Medical Society of Wisconsin and the American Medical Association.

Surviving are his widow, Roberta, and a son, Arthur, Jr., Madison.

Paul E. Carroll, MD, 46, Waukesha, died May 31, 1972, in Waukesha.

Born on Sept. 19, 1925, in Milwaukee, Doctor Carroll graduated from Marquette University School of Medicine in 1952 and served his internship at Columbia Hospital, Milwaukee. His residency was taken at Milwaukee Lutheran Hospital. He was chief of obstetrics at Waukesha Memorial Hospital from 1961–1969 and served with the U.S. Army Air Force during World War II.

Doctor Carroll was a fellow of The American College of Obstetricians and Gynecologists and a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Edith; three sons, Joel, Geoffrey, and Brian; and five daughters, Mary, Sharon, Maureen, Katherine, and Monica, Waukesha.

Theodore P. Saketos, MD, 77, Wauwatosa, died June 14, 1972, in Milwaukee.

Born June 30, 1893, in Greece, Doctor Saketos graduated from Marquette University School of Medicine in 1927 and completed his internship at Milwaukee County General Hospital. In 1970, he was given an award by Deaconess Hospital for his 40 years of service and was reappointed to its active staff in 1972. He also was honored as a member of the Half-Century Club of the University of Wisconsin–Milwaukee in 1972. Doctor Saketos had worked part time for the past two years. He took a leave from his work May 30 to vacation for the summer intending to return to his practice in September.

He was a member of the American–Wisconsin Academy of Family Physicians, The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Victoria, and a daughter, Mrs. Dean P. Spyres, Wauwatosa.

Sidney J. Silbar, MD, 76, Milwaukee, died June 15, 1972, in Milwaukee.

Born on Oct. 20, 1895 in Milwaukee, he graduated from Marquette University School of Medicine in 1922 and received a Master of Science degree from the University of Pennsylvania in 1924. Doctor Silbar served his internship at Mt. Sinai Hospital, Milwaukee, and a residency at Eastern State Penitentiary in Pennsylvania. He served in the United States Army Medical Corps during World War II. Doctor Silbar was an assistant professor at Marquette University School of Medicine for 25 years, was a staff member at Mount Sinai and Doctors Hospital, and a member of the executive committees at both hospitals.

He was a past president of the Milwaukee Urological Society and a co-founder and past president of the Wisconsin Urological Society. He was a board member of the American Board of Urology, the American Urologic Association, and the North Central Urological Association.

Doctor Silbar became a member of the "50 Year Club" of the State Medical Society of Wisconsin in 1972. He also was a member of The Medical Society of Milwaukee County and American Medical Association.

Surviving are his widow, Anita; a daughter, Mrs. Wilbert (Mitzie) Wiviott, Bayside, and a son, John D. Silbar, MD, Fox Point.

Jack E. Gruender, MD, 53, Milwaukee, died June 23, 1972, in Milwaukee.

Born on Oct. 2, 1918, in Milwaukee, he graduated from George Washington Medical School in 1943 and served his internship and residency at the Great Lakes Naval Hospital and at Cottage Hospital, Santa Barbara, Calif., respectively.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two sons, Mark and Crane, Milwaukee.

Elizabeth Kundert, MD, 82, Eau Claire, died July 2, 1972, in Eau Claire.

Born on Feb. 6, 1890, in New Glarus, Doctor Kundert graduated from the Woman's Medical College, Philadelphia, in 1926. She was on the staff of the University of Vermont Medical College before coming to Eau Claire in 1955 where she was a consultant in Northern Colony and Training School, and assisted at the Eau Claire County Guidance Clinic and the City–County Health Dept.

She was a member of the American Psychiatry and the American Ortho-Psychiatry Associations. □

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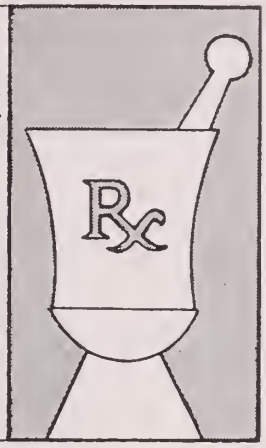

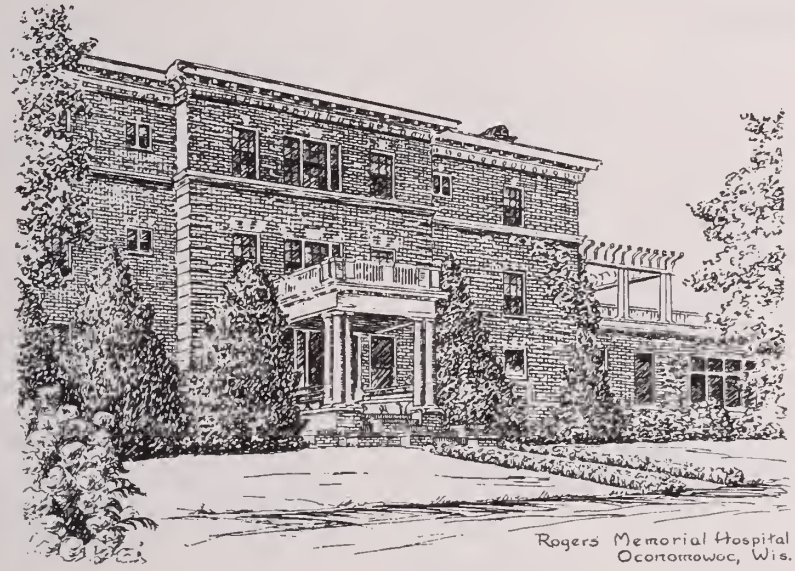

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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MILWAUKEE OFFICE—367–3172

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American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS AUGUST 1972

The Annual Meeting

The American Association of Medical Assistants, Inc.–Wisconsin Society, held their 17th Annual Meeting on May 19, 20, 21, 1972 at Leatham Smith Lodge in Sturgeon Bay.

The Annual Meeting opened with the Executive Board carrying forward and onward the business of the Society.

During the same hours a Mini-Test was held for members wishing to familiarize themselves with the format of the National Certification Examination. The Certification Examination is presented in three categories—Administrative, Clinical, and Dual. The member takes the Mini-Test in whatever category suits the member's experience or most applicable to the type of training or work the member performs. All members realize "In Education There Is Strength", so in the Mini-Test, it provides a basis for a course of study which will lead to Certification and also areas in which the member can improve.

On Saturday the general session opened with President, Dolores Mitka, presiding.

The first speaker, William Wilcox, Clinic Manager of the Krohn Clinic in Black River Falls, brought to the members and guests the office workings in all aspects. Those in attendance could relate to all the big, small, everyday ups and downs. The many duties, such as: answer the telephone, schedule appointments, receive patients in a friendly manner, obtain medical records from patients, assist the doctor, arrange hospital admissions, order medical supplies, bill and post accounts, type medical reports and insurance forms, etc. This would be a typical day.

Clarence Novotny, MD is associated with the West Side Clinic of Green Bay and spoke of the Emergency Ward System at St. Mary's Hospital in Green Bay. This was of much interest to all in helping to realize the tremendous service these departments in many hospitals are providing today.

Professor George Walter of Lawrence College, Appleton, presented his message with his unique ability to communicate and with his boundless energy and enthusiasm. Enthusiasm is something one cannot buy. The best way to acquire it, is to learn, doing new things, being interested in others and their ideas. Enthusiasm for your daily work, where most of a persons waking hours are spent, seldom makes for a boring day, discouragement or dissatisfaction. Reach out and be eager to accept the opportunities and experiences you are offered each day.

Dr. Patricia Lanier, of the Kewaunee Clinic, Kewaunee, brought slides of her travel to Europe and Russia. These do give us personal insights of the people in other countries.

The Annual Meeting has a period of time alloted for the local Chapters President and President-Elect to meet with the state President and President-Elect to discuss any need for help or advice. This is an informative time for the local chapters.

The 17th Annual Meeting offered the continued organized educational activities to the membership. The educational sessions include the latest developments in the health care field and also continuing fellowship. Professional ideas broaden the scope and effectiveness of medical assistants, we made new friends and there is the enjoyment of affiliation with others in the health field. The Annual Meeting accomplished this, we all extend our thank you for a fine meeting.

The Wisconsin Society's new elected officers are:
Marilyn Sadewater, President
Roscelia K. Linton, President-Elect
Muriel K. Taubert, Vice President
Bernadine Boulia, Secretary
Dawn Schultz, Treasurer
Donna Schultz, Speaker of the House
Lucille Skolaski, Vice Speaker of the House □

MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1971 through Aug. 31, 1972 appeared in* JAMA *Aug. 2, 1971.*

1972 WISCONSIN

Sept. 6–8: Tenth Annual Cancer Chemotherapy Conference, University of Wisconsin, Madison. Info: Dr. G. Ramirez, 714-C University Hospitals, Madison, Wis. 53706.

Sept. 12: Fall Clinic '72—Modern Immunology, Columbia Hospital, Milwaukee.

Sept. 15–16: Joint meeting of 1972 Wisconsin Regional Meeting of American College of Physicians and the Fall Meeting of the Wisconsin Society of Internal Medicine, Holiday Inn, La Crosse. Planned under direction of Herbert W. Pohle, MD, Milwaukee, ACP Governor for Wisconsin, 425 East Wisconsin Ave., Milwaukee, Wis. 53202.

Sept. 15–16: Fall Meeting of Wisconsin Surgical Society, Maxwelton Braes (Door County). Info: P. Richard Sholl, MD, Secretary–Treasurer, WSIM, P.O. Box 551, Janesville, Wis. 53545.

Sept. 15–17: Annual Meeting, Wisconsin Radiological Society, Pioneer Inn, Oshkosh.

Sept. 19: Symposium on Primary Prevention of Heart Attack—Consumer Health Education, Hotel Pfister, Milwaukee.

Sept. 23: Cancer Conference, Marshfield Clinic Foundation for Medical Research and Wisconsin Division of American Cancer Society, Marshfield.

Sept. 23–24: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept. 29–30: Functional Methods for Treating Pain, Dept. of Psychology, UW–La Crosse and The Pain Rehabilitation Center, Viterbo College Fine Arts Auditorium, La Crosse.

Oct. 6–7: Wisconsin Society of Obstetrics and Gynecology, Pioneer Inn, Oshkosh.

Oct. 21: Immunology Symposium sponsored by Marshfield Clinic Foundation, in Marshfield.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

Nov. 10–11: Wisconsin Neurological Society, Wisconsin Dells.

Nov. 11: Pediatric Symposium sponsored by Marshfield Clinic Foundation, in Marshfield.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

1972 NEIGHBORING STATES

Oct. 12–14: Recent Advances in Infectious Diseases, American College of Physicians, Mayo Memorial Auditorium, University of Minnesota, Health Sciences Center, Minneapolis, Minn. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Oct. 14–20: Annual Otolaryngologic Assembly of 1972, Eye and Ear Infirmary of University of Illinois Hospital, Chicago, Ill. Info: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

Oct. 28: Illinois Regional Meeting, American College of Physicians, Drake Hotel, Chicago, Ill. Info: Robert M. Kark, MD, 1753 W. Congress Pkwy, Chicago, Ill. 60612.

Nov. 8–10: Internal Medicine Grand Rounds, American College of Physicians, Mayo Clinic, Rochester, Minn. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Nov. 13–18: Course in Laryngology and Bronchoesophagology, Department of Otolaryngology of Abraham Lincoln School of Medicine and University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill. Info: Dept of Oto., U of Ill. Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 24–25: Conference on Radiology in Otolaryngology and Ophthalmology, Chicago, Ill. Info: Galdino E. Valvassori, MD, Radiology Dept., Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 25: Minnesota Regional Meeting, American College of Physicians, Radisson Hotel, Minneapolis, Minn. Info: Howard L. Horns, MD, 100 Melbourne Ave. SE, Minneapolis, Minn. 55414.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Sept. 24–28: Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Convention Center, Dallas, Tex.

Oct. 2–6: Annual Clinical Congress, American College of Surgeons, Fairmont Hotel, San Francisco, Calif.

1973 WISCONSIN

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

1973 NEIGHBORING STATES

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

* * *

7th Annual Cardiovascular Symposium entitled, "Congestive Heart Failure," to be held at the University of Wisconsin at La Crosse, Wednesday, October 25, sponsored by The Adolf Gundersen Medical Foundation and the Wisconsin Heart Association.

As in previous years this will be a one-day program with talks in the morning beginning at 9 a.m. by each of five prominent speakers to be followed in the afternoon by a panel discussion including the treatment of classic cases of congestive heart failure and the discussion of questions and answers from the audience.

Speakers for the 1972 Symposium are as follows:

MARK D. ALTSCHULE, MD—Clinical Professor of Medicine, Harvard University; Associate in Medicine, Beth Israel Hospital, Boston, Mass. Title of his talk: *Chronic Cardiac Decompensation—A Disease of the Whole Body.*

EDMUND H. SONNENBLICK, MD—Associate Professor of Medicine, Harvard Medical School, Boston, Mass., Director of Cardiovascular Research, Department of Medicine, Peter Bent Brigham Hospital; Co-Director of the Cardiovascular Unit, Peter Bent Brigham Hospital, Boston, Mass. Title of his talk: *The Mechanisms of Myocardial Failure.*

EZRA A. AMSTERDAM, MD—Assistant Professor of Medicine, Assistant Professor of Pharmacology, Chief of the Coronary Unit, Section of Cardiovascular Medicine, Department of Internal Medicine, University of California School of Medicine, Davis, Calif. Title of talk: *New Understanding of the Pharmacology of the Failing Myocardium—Digitalis, Catecholemines, and Metabolic Interventions.*

JOHN H. LARAGH, MD—Professor of Clinical Medicine, Columbia University;

Director, Hypertension, Nephritis Clinic, Presbyterian Hospital; Attending Physician, Presbyterian Hospital, New York City. Title of his talk: *Mechanisms of Action and Use of Diuretics in Congestive Heart Failure.*

HAROLD CLIFTON URSCHEL, JR., MD—Associate Clinical Professor of Thoracic and Cardiovascular Surgery, University of Texas Southwestern Medical School, Dallas, Texas. Title of his talk: *Surgical Consideration for Patients in Congestive Heart Failure.*

Postgraduate Conference on Pediatrics. One and one-half days at Iowa Memorial Union on the University of Iowa (Iowa City) campus Wednesday and Thursday, September 13–14.

Following a case presentation Wednesday morning, phototherapy, hypoglycemia and respiratory distress will be discussed. Afternoon topics are carbohydrate disorders of the neonate; oxygen: its uses and toxicity; and uses and abuses of phototherapy. Small group sessions on a variety of infant and child medical problems will follow.

"Intrauterine Malnutrition," "Cobwebs in the Nursery" and "Infants of Diabetic Mothers" will be Thursday's discussion topics.

Guest faculty members for the conference are Drs. Marvin Cornblath, University of Maryland, Jerold Lucey, University of Vermont and William Tooley, University of California, San Francisco.

For registration information, write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240.

Genito–Urinary Cancer Symposium. Many of the nation's leading urologists are expected to attend this special symposium at the University of Iowa (Iowa City) Friday and Saturday, September 15–16.

Symposium will honor Dr. Rubin H. Flocks, professor and head of the U of I Department of Urology since 1949, for his many contributions and years of interest and leadership in the field of urology, especially in urologic oncology.

Among symposium topics will be "Electronmicroscopy of the Prostate," "Cryosurgery for Prostatic Carcinoma," "Management of Bladder Tumors," and "Methods of Urinary Diversion in Treatment of Malignancy."

Guest faculty members for the conference are Drs. Ormond Culp, Mayo Clinic; John Grayhack, Northwestern University; Hugh Jewett, Johns Hopkins University; Willoughby Kittredge, Ochsner Clinic, and president of the American Urological Association; William Valk, University of Kansas Medical Center; and Anthony Walsh, University of Dublin, Ireland.

For registration information, write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240.

Fetus and Newborn in High-Risk Pregnancy. The University of Wisconsin Center for Health Sciences–Madison and the Wisconsin Perinatal Center–South Central Region will present a postgraduate course on the Fetus and Newborn in High-Risk Pregnancy, September 28–30, at the Wisconsin Center in Madison.

Course is open to all doctors and nurses who are interested in acquiring some newer concepts and approaches to assessing the fetus and neonate of specific high-risk pregnancies.

Guest faculty includes Dr. J. S. McDonald, Asst Prof of Anesthesiolgy, Univ of Southern California; Dr. E. J. Quilligan, Prof of Obstetrics, USC; and Jane Turbeville, RN, Perinatal Nursing Specialist, USC. Twenty-five members of the Wisconsin Perinatal Faculty also will actively participate in this program.

Course will consist of formal presentations, panel discussions, obstetric and neonatal workshops, and question–answer sessions. Many topics will be covered including fetal nutrition and biochemistry, antepartum fetal assessment, genetic risk detection and counseling, premature labor problems, problems of premature rupture of membranes, and specific maternal disorders (hypertension, diabetes, etc.).

Obstetric workshops will consider fetal heart rate monitoring, treatment of fetal distress, and discussion of representative tracings. Neonatal workshops for doctors and nurses will deal with catheter use in the newborn, radiological diagnoses, seizures and maternal–infant relationships in regard to early separation. Obstetric anesthesia, newborn assessment and newborn resuscitation also will be covered.

Further info: Dr. J. M. Schneider, Fall Postgraduate Course, 202 South Park St., Madison, Wis. 53715.

Third Annual Meeting on Antibiotics and Infection will be held at the University of Iowa on Thursday, Friday, and Saturday, October 26–28. As well as 30 speakers from the University of Iowa Faculty, there will be five guest speakers: Dr. Elisha Atkins of Yale University Medical School, Dr. King K. Holmes of the USPHS in Seattle, Washington, Dr. Calvin M. Kunin of the University of Wisconsin, Dr. William R. McCabe of Boston University, and Dr. David H. Smith of Harvard Medical School. Inquiries should be made to Dr. Ian M. Smith, Department of Internal Medicine, University Hospitals, Iowa City, Iowa 52240.

American College of Chest Physicians will hold its 38th Annual Scientific Assembly October 23–26, 1972 in Denver, Colo. Four-day educational program will feature workshops, symposia, guest lectures, fireside conferences, tutorial sessions and the presentation of 86 scientific papers. A day of clinic visits to 11 hospitals and teaching centers in Denver has been scheduled for the opening day of the scientific assembly. In addition, there will be a one-day national seminar for nurses and inhalation therapists on modern methods of managing patients with critical cardiopulmonary problems, and a one-day workshop for physician–authors on scientific writing.

A special tour program has been arranged for wives attending the meeting, and a post-convention group tour for all participants will be available. Registration fee information and advance registration forms are available from the ACCP offices, 112 East Chestnut Street, Chicago, Ill. 60611.

Annual Scientific Assembly of Interstate Postgraduate Medical Assn. will be held at the Washington–Hilton Hotel, Washington, D.C., November 13–16. Primarily designed for Family Physicians and Internists the Assembly is an educational service providing a diversified lecture program, "live" Television, medical motion pictures and panel discussions. Special symposia on "Diabetes," "Pediatric Problems in Office Practice," "Urinary Infections," "Hypertension" and "Anemia" are included in the program. Faculty members of George Washington, Georgetown and Howard Medical Schools provide major portions of the instruction.

Guest speakers include Walter F. Ballinger, MD, St. Louis; Daniel H. Mintz, MD, Miami; Rubin Flocks, MD, Iowa City, Iowa; C. Barber Mueller, McMaster University, Hamilton, Ontario; Edward D. Freis, MD, VA, Washington; Ray W. Gifford, Jr., MD, Cleveland; Douglas G. Cameron, MD, McGill University, Montreal; Paul H. Curtiss, Jr., MD, Columbus, Ohio; Carroll M. Leevy, MD, Newark; Robert H. McDonald, MD, Pittsburgh; Edward F. Rabe, MD, Boston; Robert E. Cooke, MD, Baltimore.

Meeting is open to any licensed MD in the U.S. or Canada. Fee is $25 for 26 hours of instruction, which provides credit for members of the American Academy of Family Physicians who attend.

Those interested in further details and registration forms should write to Alton Ochsner, MD, Program Chairman, Interstate Postgraduate Medical Assn., P.O. Box 5445, Madison, Wis. 53705.

Cleveland Clinic Educational Foundation—Postgraduate Schedule: 1972–73.

Nov. 10: Clean Air Symposium

Nov. 15–16: Gastroenterology—Current Topics

Dec. 6–7: Current Concepts in Ophthalmology

Jan. 17–18: Managing the Complicated Surgical Patient

Jan. 31–Feb. 1: Medical Progress for the Family Physician

Feb. 7–8: Drugs and Treatment Techniques in Angiography

Feb. 21–22: Pharmacology and Clinical Effectiveness of Anti-inflammatory Drugs

Feb. 28–Mar. 1: Sports Medicine

Mar. 14–15: Advances in Urology

Mar. 21–22: Hodgkins Disease, Leukemia and Lymphoma

Mar. 28–29: Treatment of Neurological Diseases

Apr. 11–12: Orthopaedic Surgery

Apr. 25–26: Peripheral Vascular Disease

May 5–6: Organization and Administration in Anesthesiology

May 9–10: Advances in Dermatology

Info: Cleveland Clinic, Education Division, Walter J. Zeiter, MD, Director, 9500 Euclid Ave., Cleveland, Ohio 44106; tel. 216/229–2200.

Fall Clinic '72—Modern Immunology, Columbia Hospital, Milwaukee, Sept. 12, with registration starting at 8:30 a.m.

Program starts at 9:30 with an Introduction to Modern Immunology by Dr. Bernard Pirofsky, Professor of Medicine, Head of Division of Immunology and Allergy, Oregon Medical School Hospital and Clinic, Portland, Ore., and Dr. Richard D. Fritz, Associate Clinical Chairman of Medicine, Medical College of Wisconsin (MCW), and Chief of Medicine, Columbia Hospital, Milwaukee.

The subject of Oncology will be discussed by Dr. Charles F. McKhann, Professor of Surgery and Microbiology, University of Minnesota Hospitals, Minneapolis, Minn.; Dr. Richard R. Rudders, Assistant Professor of Medicine, MCW; and Dr. Jerome J. deCosse, Professor and Chairman, Division of Surgery, MCW.

At 11:00 the Role of Immuno-Deficiencies in Infection will be discussed by Dr. Nicholas L. Owen, Assistant Clinical Professor of Medicine, MCW; Dr. Bernard Pirofsky; Dr. Glenn E. Rodey, Associate Professor of Medicine, MCW; Dr. Lyle Heim, Clinical Immunologist; and Dr. Michael W. Rytel, Associate Professor of Medicine, MCW.

Following a luncheon the program will resume at 2:00. Rheumatic Diseases—A Clinical Expression of Immunology will be discussed by Dr. Glenn E. Rodey; Dr. Eugene V. Barnett, Professor, Department of Medicine, University of California Center for Health Sciences, Los Angeles, Calif.; Dr. Gerson C. Bernhard, Associate Clinical Professor of Medicine, MCW; and Dr. Bernard Pirofsky.

At 3:45 the subject will be Clinical Applications of Newer Immunological Concepts. Discussants will be Dr. David G. Kamper, Clinical Instructor in Medicine, MCW; Dr. Eugene V. Barnett; Dr. Douglas D. Klink, Associate Clinical Professor of Medicine, MCW; Dr. George E. Whalen, Jr., Associate Professor of Medicine, MCW; and Dr. Charles F. McKhann.

Dr. Wayne J. Boulanger, Associate Clinical Professor of Surgery, MCW, and Chairman, Department of Surgery, Columbia Hospital, will be the speaker for the evening dinner at the University Club of Milwaukee. His subject will be Medicine and Poetry—A Legitimate Alliance?

Fifth Western Hemisphere Congress. International College of Surgeons, Nov. 12–16, Town & Country Hotel, Convention Center, San Diego, Calif. General scientific sessions and postgraduate courses approved for Category A Credit for Continuing Medical Education by CMA and AMA. PG courses in Cancer Therapy, Colon and Rectal, Head and Neck, Obstetrics–Gynecology, Total Hip Arthroplasty, Shock, Anatomy of Abdomen, Thoracic Surgery, Urological Surgery, Vascular Surgery. Info: 5th Western Hemisphere Congress, 136 N. Brighton St., Burbank, Calif. 91506.

Primary Prevention of Heart Attack: Consumer Health Education. Prevention of coronary heart disease through better public understanding will be the subject of a one-day symposium to be held September 19 at the Pfister Hotel in Milwaukee. Sponsored by the Milwaukee Area Committee on Employment of the handicapped. Cooperating sponsors include the Governor's Committee on Employment of the Handicapped, the President's Committee on Employment of the Handicapped, the Medical College of Wisconsin, the American Heart Association, the Wisconsin Heart Association, the Medical Society of Milwaukee County, and the State Medical Society of Wisconsin.

Intended to alert grass root health professionals and health interested laymen to the seriousness of the prevalence and distribution of coronary heart disease, and to stimulate their participation in primary prevention of the disease through consumer health education.

It will bring together professionals and laymen involved in lay health program development from official and voluntary agencies, medical and public health organizations, schools, colleges and Universities, business, industry, labor, the mass media, and a broad range of specialists including physicians, health educators, nurses, nutritionists, social workers, psychologists, sociologists, teachers, therapists, and vocational and rehabilitation counselors.

George A. Hellmuth, MD, is scientific chairman of the symposium and professor of physiology at the Medical College of Wisconsin.

Several worldwide experts on coronary heart disease and consumer health education have accepted invitations to participate. The speakers and their topics include Paul Dudley White, MD, professor emeritus of medicine, Harvard University Medical School, "Importance of Consumer Health Education for the Health Professions in Primary Prevention of Coronary Heart Disease";

Oglesby Paul, MD, former president of the American Heart Association, "High Risk Factors and Primary Prevention of Coronary Heart Disease"; Mildred McIntyre, RN, former chairman of the Council on Cardiovascular Nursing of the American Heart Association, "Role of the Nurse in Consumer Health Education in Primary Prevention of Coronary Heart Disease"; Yolanda Hall, MS, nutritionist, "The Nutritionist as Health Educator in Primary Prevention of Coronary Heart Disease";

Samuel Fox III, MD, president of the American College of Cardiology, "Physical Conditioning in the Community for Primary Prevention of Coronary Heart Disease"; Godfrey Hochbaum, PhD, professor of health education and behavioral sciences, University of North Carolina, "Sociological and Psychological Aspects of Primary Prevention of Coronary Heart Disease"; George Reedy, dean designate, College of Journalism, Marquette University, "Mass Media and Consumer Health Education"; Paul Pugh, vocational counselor, Cardiac Work Evaluation Unit, Seattle, "Responsibilities in Primary Prevention of Coronary Heart Disease of Rehabilitation and Vocational Counselors"; and

Ogden Johnston, PhD, director of Division of Nutrition, Food and Drug Administration, "Role of the Food and Drug Administration in Primary Prevention of Coronary Heart Disease in Relation to Food". There will also be nationally known speakers on health insurance and citizen involvement in health education.

Symposium planners indicated they expect to broaden the impact of the symposium beyond the audience attending through the publication and distribution of a book containing addresses presented at the symposium.

Tenth Cancer Chemotherapy Conference. The Division of Clinical Oncology of the University of Wisconsin will hold its 10th Cancer Chemotherapy Conference September 6–8 at the Park Motor Inn, Madison. Conference is open to all United States physicians interested in cancer chemotherapy. It will review and present a forward look at anti-cancer therapy of solid tumors and leukemias as well as the role of radiotherapy, immunology and virology in the treatment of cancer.

Guest faculty: J. Palmer Saunders, PhD, director of Extramural Activities, National Cancer Institute, Bethesda, Md.; Loren J. Humphrey, MD, Professor and Chairman of Surgery, University of Kansas Medical Center, Kansas City; Emil J. Freireich, MD, Professor of Medicine and Chief of Research Hematology, M.D. Anderson Hospital and Tumor Institute at University of Texas in Houston; and faculty from McArdle Laboratory for Cancer Research and Division of Clinical Oncology at University of Wisconsin–Madison.

Further information: G. Ramirez, MD, 714-C University Hospitals, 1300 University Ave., Madison, Wis. 53706. □

Two-week

Maternity and Pediatric Nursing Programs

jointly sponsored by the Division of Health for the coming year 1972–73:

Programs designed for registered nurses who are currently employed in a maternity or pediatric department of a hospital or anticipate returning to work in the immediate future in these specialty areas.

Beginning dates of Maternity Program: October 9, November 6, January 15, February 19, March 19, and April 23. Application or inquiries should be directed to: Miss Virginia Mecikalski, RN, Marquette University College of Nursing, 3029 North 49th Street, Milwaukee, Wis. 53210.

Beginning dates of Pediatric Program: September 11, November 6, January 29, March 26, and May 7. Applications or inquiries should be directed to: Miss Mary Beckman, RN, Division of Health, Community Health Services, P.O. Box 309, Madison, Wis. 53701.

CONTRIBUTIONS—CES FOUNDATION

June 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for June 1972:

Nonrestricted

State Medical Society Members	Voluntary contributions of 26 MDs
Dane County Medical Society	Memorial: Arthur C. Stehr, MD
Margaret K. Pharo, Marguerite Cordts, Mr. and Mrs. Robert H. Schulz	Memorial: B. E. Swihart
Dave and LaVonne Beale	Memorials: Col. Humbert J. Versece, Mr. George Piper
Wisconsin Physicians Service	Memorial: Mr. George Piper, Charles Benkendorf, MD
Wisconsin Radiological Society	Memorials: Lawrence L. Larsen, MD, Charles Benkendorf, MD
Harold and Evelyn Schulz	Memorial: William Tubesing
State Medical Society	Memorials: F. L. O'Keefe, MD, A. C. Stehr, MD, P. E. Carroll, MD, R. E. Fitzgerald, MD, T. P. Saketos, MD, S. J. Silbar, MD

Charitable Disabled Physicians

State Medical Society Members	Voluntary contribution of 1 MD

Student Loans

State Medical Society Members	Voluntary contributions of 2 MDs
Karl P. Grill, MD	Contribution
NMC Projects Inc.	Contribution

W. W. Hildebrand, Esq. and G. B. Hildebrand, MD

William B. Hildebrand, MD	Contribution

Medical Student Summer Externship Program

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Barbara Scott Maroney Memorial Fund for Research on Diabetes

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Fund for Deaf and Hard of Hearing

DeForest Class of 1972—Fund for the Deaf, John M. Grinde, MD	Contribution

□

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the wisconsin medical journal

official publication of

THE STATE MEDICAL SOCIETY OF WISCONSIN

SEPTEMBER 1972

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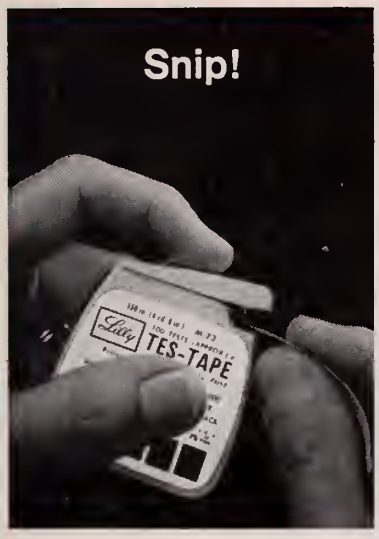

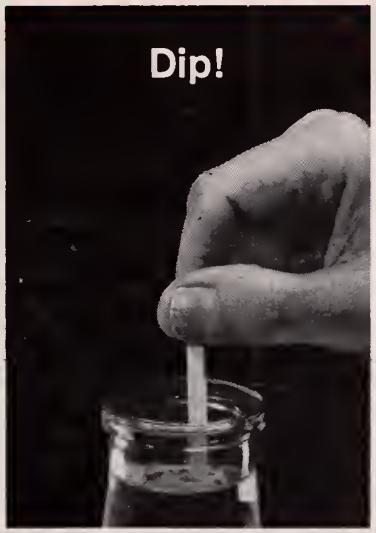

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Quality Control

PRESIDENT'S PAGE

QUALITY IS, at best, a difficult thing to define or appraise. Quality has been defined as that which distinguishes one person or thing from others such as color, weight, experience, degree of excellence, training—and much more.

American business spends hundreds of millions of dollars each year attempting to impress potential buyers with the quality of its product. Much of it is pure fantasy—for example, a beautiful mountain stream to sell Salem cigarettes. How do you convey the quality of Bushmill's Irish whiskey—or a Vega?

Are our patients—I refuse to refer to my patients as consumers—interested in the matter of quality of medical care? You bet they are! Let me quote Dr. Harry Schwartz, PhD in Economics and on the Editorial Board of the *New York Times,* who addressed the Organization for State Medical Association Presidents during the AMA Convention last June. This man and his family have undergone an unbelievable series of major surgical experiences. Doctor Schwartz had this to say: ". . . Out of this traumatic background has come a certain set of convictions, and among them, of course, is a conviction that the most important thing in medical care is quality. And I'm awfully disturbed very frequently that quality goes unmentioned." He had much more to say on the subject of political and governmental interference in the areas of medical care—again on the subject of quality versus quantity.

When one sets out to estimate quality or to establish quality control as it relates to medical care, an endless net of questions and standards evolves. Woven into the fabric of today's medical care is often the combined efforts of a team all working in concert with the physician and his consultants. The modern hospital with its complex battery of diagnostic and therapeutic equipment is deeply involved in keeping pace with good medical care.

The record of our State Medical Society as it relates to the improvement of the quality of medical practice in Wisconsin speaks for itself. For the past many decades our Society has sponsored a wide variety of postgraduate teaching programs aimed always at bringing new developments in medicine to physicians throughout our State. We are all well aware of the splendid work in the field of maternal and child care, the prematurity institutes, and the development of minimal standards for delivery rooms and more.

At the 1971 meeting of the House of Delegates a resolution calling for the development of a statewide peer review mechanism was ordered. The Wisconsin Health Care Review, Inc. was founded in December 1971 by the State Medical Society of Wisconsin, the Wisconsin Hospital Association, and the Wisconsin State Dental Society. This non-profit organization will be the cornerstone in developing guidelines and standards to be applied at the local level in the delivery of quality health care throughout our State. I would admonish each member of our Society to keep well informed and ready to speak out on this very sensitive and very important subject of quality control as it relates to health care.

Consumerism is with us. Consumers are insisting on a voice in determining what is good medical care. Much more is involved such as medical fees and hospital charges. It is my own strong belief that only professionals can judge professionals. I would feel quite inept in any effort to judge the work of an electrical engineer or a metallurgist. I believe that even the most well motivated consumer would find himself in the same quandary.

Robert F. Purtell, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Transition—one of a series

It is comforting to believe that those things we know and those things we do are pertinent to our lives and to the lives of those around us. It becomes disquieting to consider changes. This fact of discomfort with new things is an old story with mankind. We seem to stagger along striking somewhere a balance between leaving things just as they are and the other extreme of revolutionary upheaval.

In this editorial and others to follow, your attention will be directed toward interlaced but discrete facets of the transition we as physicians are facing in a world that seems unable, or at least unwilling, to stand still. While I cannot predict the future, I can address myself to current changes and by careful study of these, venture some predictions.

Because of both social and technical change none of us can be certain anymore that our hard won knowledge will be valid in the future. In the past changes came more slowly. New medical specialties took decades to form, longer to form American boards, and then stayed put. Today, even in my own professional lifetime, there have been significant major changes in the technical aspects of psychiatry.

After spending a decade learning psychoanalysis, a most subtle and complex skill, I find myself "hoping" that my sort of practice will last me out until some semi-mythical retirement age. Other specialties such as Ear-Nose-Throat have slackened, or at least changed, with technical introduction of new chemical and surgical methods of treatment. But we also are caught in the web of social change which seems to dismay and disgruntle us. Again and again I hear the cry in various medical councils that I listen to or work with: "but there wasn't a single member of . . . (this or that board or health commission) . . . who actually sees patients on an individual basis."

Some advanced health action plans do include medical persons, usually as a token, for he is rarely a practitioner but rather an administrator or educator. It is tempting to believe that this shift away from using the knowledge of the physician is out of respect for his busy schedule, but none of us believes that. It is easy, too, to take the darker view

that it is all a plot to eliminate us, or at least downgrade us to a menial level, with even competency being judged not by our peers but by our consumers, or worse by some general "concerned" community group.

I do not know which of these two polarities to believe. I try to avoid the grandiose attitude because, tempting as it is to believe that I have special answers, it's just not true. And if I wander too far into the paranoid view, I begin to sound strange even to myself.

Change may not be all that bad. In industry men are trained to change or at least to be able to change. In our medical schools the same plan is stated—that we will teach only a sampling now and leave the physician-to-be to his own devices for future learning.

It may take more than that to keep our heads above water. Two quick examples. "The Revolutionary Physician" by John McNamara, MD, writing in the *New England Journal of Medicine* (July 27, 1972), describes a group of young physicians who boldly attempted to put into live action their humanitarian beliefs. They make slight of our time-honored, doctor-patient relationship, vowing instead to serve directly and well the entire community. They would have minor services available on every block and preventive medicine done door-to-door. This paper is well worth your reading for it might give a view of things to come.

The other example, which seems not to be working as well, is that of a free clinic in this state, supported partly by church money. The board of directors, who really do hold control in true establishmentarian manner, simply decided that the money donated by the church for services and medicine would serve the people better if used for political ends. In a previous editorial I told of this usurpation for overriding political reason of a South American academic department. These examples are close to home.

The implications of this first premise—that none of us can be sure any longer how valuable will be our slowly won skills—are varied. Foremost is the need for flexibility which means, of course, the capacity to even consider whether our well developed skills and approach to medical delivery might not be the best, or the only, way. This may be the hardest thing to do, but there are others. Periodic learning experiences are now a must.

It is expensive both in money and time away from practice, as well as expensive to our egos, to go and learn again. Annually I spend about a week examining and learning in our American Boards and about the same amount of time in our American College which gives regular formal courses. Other specialties do the same, but it is hard to do and yet most likely will be more demanded, not just to put down on paper or for credit, but to survive in this tumultuous world.

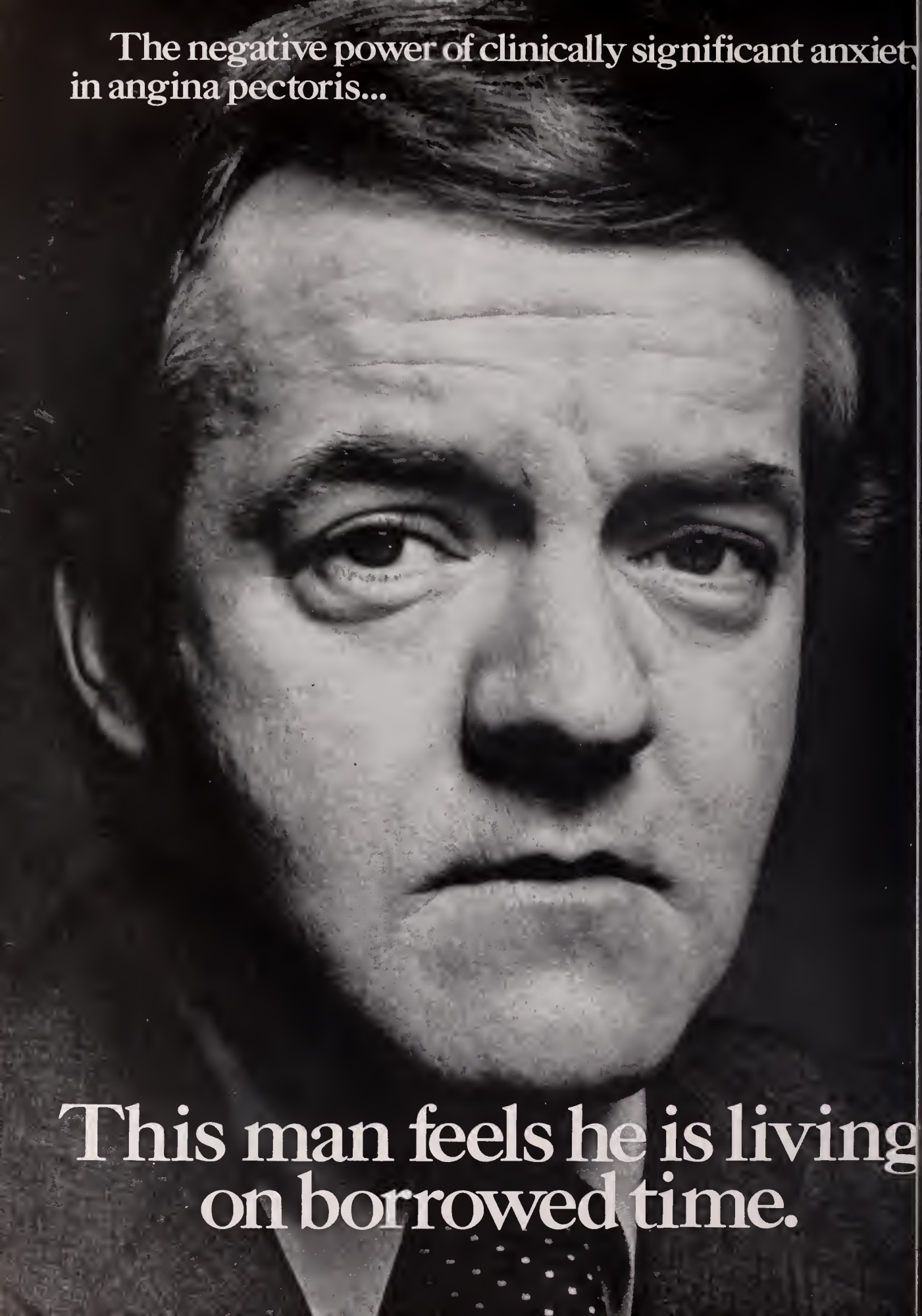
Another thing that is happening is that professional persons are making even shorter commitments to specific careers, hence more persons are making changes, mid-life or older. The concept of "serial-careers" is seen in various writings and may well become acceptable and even desirable, even for physicians. I am not referring to a physician getting tired of the demands of private practice, tossing everything over and looking for an industrial position or an anatomy teaching post, but rather the implication of seriously planned changes, plus the ability to sense changes and include them in a person's life style, even if not foreseen.

A further implication of this basic idea, namely that we have no assurance that our values will last, is that there may likely emerge a specialty of planning, defined as in these paragraphs. That such a person should be qualified in medicine first seems obvious and right. Yet what in our medical school years, and even in our daily practice, really fits us to do this? Since it must be done, we risk being left because of lack of skills that are pertinent, or in the language of our children—relevant!

Last, but not least, the traditional values of privacy and freedom may change from what we have known and cherished. The reason for this is relatively simple. Effective and/or extensive social planning, in medicine or in any other field, requires vast stores of information. It is all very well to speak of the anonymity of the computer, but the computer can be unscrambled as we well know, if it should prove necessary. And who decides if it is necessary? Beyond that, the need for such information may erode our sense of freedom over just such matters as what personal information is to be given, and given to whom others?

In the months to follow, further social and technical change potentials will be discussed. These will include: the possibility that in some manner these changes can expand the range of choices available to us; the possibility that the new choices cannot be made on the basis of traditional values; the very real possibility that all this can lead to confusion and even heightened conflict; and the possible emergence of a new sort of use of an intelligence, addressed not to cellular pathology, precise surgery, or reconstructive psychoanalysis, but to *organization* as a thing to be studied and used for our gain.—RH

The negative power of clinically significant anxiety in angina pectoris...



This man feels he is living on borrowed time.

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Librium (chlordiazepoxide HCl) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is clinically significant. The drug should be discontinued after anxiety has been reduced to appropriate levels.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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*Levine, S.: "Angina Pectoris and Emotional Overlay," Scientific Exhibit presented at the Annual Meeting of the Maine Medical Association, Kennebunkport, Me., June 13-15, 1971.

A copy of the Levine study may be obtained from your Roche representative.

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STATE MEDICAL SOCIETY OF WISCONSIN

OFFICIAL CALL for Scientific Exhibits

1973 ANNUAL MEETING, MILWAUKEE

March 26–27

Pfister Hotel—Scientific Exhibits and Program

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1973 Annual Meeting. The exhibits will be located in **Milwaukee.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1973 meeting are requested to file an application before *Oct. 1, 1972,* giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Space assignments will be made as exhibits approved by Commission on Scientific Medicine.*

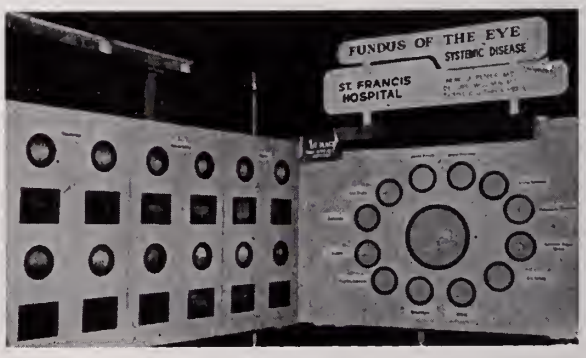
In-state exhibitors will have the following facilities provided by the State Medical Society: Fiberglass draping and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, electrical connections, shelving or tables, and special lighting equipment (rented through Badger Exposition Service, Inc., Milwaukee, on form to be furnished all exhibits scheduled).

Booths for scientific exhibits will have fiberglass background, 8′ in height, and 8′ fiberglass side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level through Badger Exposition Service, Inc.



Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: OCT. 1, 1972.**

Address your communications to:

FREDERICK D. COOK, MD
Chairman of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison, Wis. 53701

USE FORM ON FOLLOWING PAGE →

STATE MEDICAL SOCIETY OF WISCONSIN

APPLICATION

FOR PARTICIPATION IN THE SCIENTIFIC EXHIBITS

1973 Annual Meeting, Milwaukee—March 26–27
Pfister Hotel—Scientific Program and Exhibits

★

Fill out the following information and mail to:

FREDERICK D. COOK, MD, *Chairman of Scientific Exhibits*
State Medical Society of Wisconsin
Box 1109, Madison, Wisconsin 53701

1. Title of exhibit: _____

2. Description of exhibit (space allowed below for 200-word description): _____

3. **Feet Required:** _____ **(In figuring feet required, remember the space is 8′ deep, and your exhibit can use sides as well as back.)**
   (Space is scarce so ***do not request more than is necessary****)*

4. Will radiologic viewing boxes be used? If so, will you furnish them? _____
   (The State Medical Society does not have equipment of this character available.)

5. Name (s) of exhibitor (s): _____
   (Please Print)

   _____

   _____

6. Name of institution(s) cooperating in exhibit: _____

   _____

DEADLINE: All applications must be filed by *Oct. 1, 1972.*

A Bit of Light on the Drug Scene

IN THE LAST TEN YEARS there has been no end to moaning and groaning about drug use and abuse. Most is hysterical, or worse, uni-causal; that is, blaming some drug for a variety of ills that beset our children, or our world. Very little direct searching and almost no re-searching have been done.

The short paper appearing in this issue by Basil Jackson, MD and two medical students is one attempt to be precise in a search first for definitive information. Only by accumulation of data such as this can eventual light be shed. Your attention is directed to the article for some beginning bits of information. —RH

Toward Survival

JOSEF PREIZLER HAS WRITTEN a precisely circumscribed but valid treatise involving his work with the Wisconsin Multiphasic Screening Program. The early furor about multiple screening seems to have abated and now we are getting careful information like his "Distribution of Biochemical Values" which can be read in the scientific section of this issue. From the perspective of health delivery, it is significant that of the 8 to 10 percent of participants referred to their own personal physicians as a result of test findings, two out of three were found to have a disease. True, some of this would have been found as soon by regular medical care but some of it would have come out later, maybe much later. This program, of many new ones, is reassuring to us as physicians as well as to us as persons, who are prone also to disease and yet prone to neglect diagnostic surveys of our own selves.—RH □

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WISCONSIN MEDICAL JOURNAL
Vol. 71, No. 9 SEPTEMBER 1972

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

LEGISLATION BEING DRAFTED

Wisconsin's Health Care Utility—Shaping Up

The wraps are off the health care utility.

September 8 the Governor's Health Planning and Policy Task Force gave the green light to preparation of a law setting up a "state-level health services commission."

Task Force Chairman David Carley doesn't like to call it a utility. But that seems to be a good, hip-pocket word for this commission which would be "independent of any existing state agency" and could make rules on:

. . . FEES of physicians and other "individual health practitioners," as well as "other health care costs;"

. . . RATES of health care institutions (which may include physicians' offices);

. . . LICENSING of all Wisconsin health care institutions (which may include physicians' offices);

. . . REVIEW of health care quality; and

. . . NEED for additional health institutions and services in the state (which may include physicians' offices).

One characteristic of a public utility is its ability to give an exclusive franchise for a service. It looks like this may hold true in the health services commission as well. When the commission establishes the NEED for health care services and institutions in an area, it can then authorize a limited number of people and institutions to meet that need. In effect, physicians and hospitals authorized to provide health care to an area would hold the franchise for that area.

Mr. Carley termed the health services commission the most important item to come out of the Task Force's year and one-half of deliberations.

It is not clear at this point how much power the three-member commission would have over physicians' fees. A clearer picture may come next month when the Task Force sees a draft of the bill to be sent to the Legislature.

"Evaluate" Fees. According to the wording of the proposal passed by the Task Force, the commission would "compile, evaluate, and comment" on fees to bring them to the public's attention. However, the possibility that the commission might eventually regulate fees was not ruled out.

There was little debate over the need for such a commission. However, State Health Officer George Handy, MD, tried unsuccessfully to have the Task Force recommend that the job be done by the State Department of Health and Social Services (DHSS).

Doctor Handy said DHSS already has responsibility in most of these areas and the establishment of a new agency would add a superfluous additional bureaucracy.

Mr. Carley replied that DHSS is "programmatic in nature" and the regulatory body must be an independent commission.

Bonding Authority. Another facet of the utility may be revealed soon in still another Task Force working paper. This is a bonding authority to help institutions raise money for expansion projects. The advantage of this approach is to help the institution float bonds at less cost.

The Wisconsin Supreme Court is currently considering the constitutionality of this approach in connection with a state housing bonding authority law which was passed during the last session of the Legislature. If the court rules against the approach, then (presumably) it would be left out of the health utility scheme.

The Task Force proposal also envisions giving the utility powers of eminent domain in cases where health care facilities need to be constructed. If this were the case, land needed for the project would have to be surrendered much as it is for highway projects.

The Task Force's utility concept is dovetailed with a proposal on health care review released by the Task Force earlier the same day.

Health Care Review. That proposal outlined a health care review organization which would be "publicly accountable but nongovernmental." That organization may evolve from Wisconsin Health Care Review, Inc.

continued on page 26

Wisconsin Health Care Utility—Shaping Up

continued from page 25

(WHCRI), formed earlier this year by the State Medical Society of Wisconsin, the Wisconsin Hospital Association, and the Wisconsin State Dental Society.

According to Mr. Carley, licensing of health professionals is not mentioned specifically as an area of concern for the health care utility because this will come under the health care review organization. Exactly how the two will coordinate their efforts is unclear at this point.

To date, WHCRI is governed by a board made up of four physicians, two hospital administrators, and two dentists. A search is under way for three people to represent the consumer viewpoint. During discussion of WHCRI by the Task Force, some comments called for an even larger consumer contingent on the board. Further discussion and final recommendations in this area are scheduled for the October Task Force meeting.

The health care review organization (sometimes euphemistically called the "health service quality maintenance agency") and the State Medical Society also may be called on by the Task Force to review and develop new standards for non-psychiatric medical and nursing care in Wisconsin county hospitals.

Last year the State Medical Society's Division on Nervous and Mental Diseases drew up suggested staffing guidelines for community mental health facilities, termed "excellent" by Madison psychologist Peter Weiss, the Task Force member who presented this proposal. However, the extent to which the State Medical Society's recommendations have been implemented is not known.

If new standards are developed as called for in a Task Force proposal, they would then be directed through the Health Policy and Program Council and be published as new rules by July of next year.

"Home Rule" Proposed for Mental Health, Alcoholism Treatment

"Home rule" of mental health and alcoholism treatment services is a proposal now under study by the Governor's Health Planning and Policy Task Force.

At its August 9 meeting, the Task Force approved the release of this proposal made by its Subcommittee on Developmental, Behavioral, and Chronic Problems.

If finally approved by the Task Force (probably in October), legislation would be drawn up giving the "home rule" power to counties. It is proposed that a county or a group of counties set up a board which would decide how best to use funds for mental health and alcoholism treatment coming into that area from the state government. Such a board might include a mixture of citizens and program administrators.

"Fragmented" Services. A drafter of the "home rule" proposal, Walter Gleason, PhD, termed "fragmented" and "inefficient" the current organization of mental health and alcoholism services. Doctor Gleason is executive director of Walworth County Hospital–Mental Health Clinic.

The proposal would allow the local board to "shop around." It could buy wherever it decided it could get the best for its state money for alcoholism and mental health. This means it would not need to depend upon the county hospital, the traditional source of mental health and alcoholism services. Other sources of help might include general hospitals, half-way houses, group homes, residential care facilities, and family care homes.

This approach is in line with current thinking of the state Department of Health and Social Services. The Task Force is already on record asking for a change in priorities in line with this proposal. In February the Task Force took the position that public funds in this area should be directed away from residential institutions and toward community-based, ambulatory facilities.

Alcoholism Detoxification. Along with suggesting "home rule," the proposal also tabbed community hospitals as the "inpatient treatment place of choice for detoxification of alcoholics." It recommended that provision of alcoholism detoxification be a condition of a general hospital's license. The Wisconsin Hospital Association has already expressed opposition to this suggestion.

The plan calls for changing Winnebago and Mendota State Hospitals to "Mental Health Institutes" for care of hard-to-manage patients. Central State Hospital would be closed, with patients requiring inpatient treatment being transferred to either of the "Mental Health Institutes."

The proposal terms "deplorable" the difference between the way county hospitals and mental health clinics are funded and asks for a change in the way the state subsidizes these institutions.

Change in Subsidies. It asks that the full range of outpatient services be subsidized at 90 percent—double the current rate of about 45 percent. The inpatient care subsidy would start at 90 percent and decrease as the patient's stay approached one year. There would be no state subsidy for patients in residence longer than one year.

In addition, insurance companies, including the Blue Plans, would be requested to extend coverage to a range of outpatient care for mental illness, alcoholism, and other drug abuse, with no exclusions for services in public facilities. This involves millions of dollars which inevitably must be picked up in additional premiums if these coverages are mandated by the Legislature.

Since the August meeting of the Task Force at which these ideas were accepted for discussion purposes, many interested groups and individuals have been contacted for their reactions and suggestions.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

Prepaid Health Care Experimentation Given Impetus

Better health insurance does not guarantee better health.

Health Task Force Chairman David Carley pointed this out September 8 at the same Task Force meeting where two new approaches to health insurance plans were given preliminary discussion. Both approaches are related in many ways to ideas being discussed by the state's physicians. One is health insurance for the unemployed and the "uninsurable;" the other is a new form of prepaid health care.

Unemployed – "Uninsurable." When John Doe lost his job, he also lost his health insurance because he was part of a group plan where he worked; Mary Doe cannot get health insurance because of a long-standing kidney ailment.

To solve dilemmas such as those, the State Medical Society last spring proposed an innovative health care financing plan. It is geared to help the unemployed and those whose health problems have made them "uninsurable."

The Governor's Health Planning and Policy Task Force has picked up major parts of that proposal in a working paper of its own. At its September meeting the entire Task Force released the paper for public discussion along with the idea that a health insurance pool be established by state law to implement the plan.

Exactly how that pool would work still has not been decided. However, it would probably force health insurance companies to accept the "uninsurables" on an assigned risk basis, much as automobile insurers are now required to insure high risk drivers.

According to Ben Lawton, MD, Marshfield, who headed the work group that wrote the paper, "uninsurables" includes all who have a "rider" attached to their policy eliminating coverage for some health conditions. The policy offered through the pooling mechanism, he said, would be a comprehensive one and not inexpensive. He speculated that if national health insurance becomes a reality, such a plan might no longer be necessary.

Prepaid Health Care. Pointing the way toward a system of state health insurance, Task Force Chairman David Carley asked for—and got—Task Force approval to develop a prepaid health care plan for Dane County residents.

There is some skepticism among Task Force members as to whether an innovative new plan can be worked out before the group meets again October 23–24. Even Task Force vice-chairman Dr. Lawton said rather pointedly that all he has learned about prepaid health care convinces him that no one really knows too much about it.

A background paper on prepaid health care presented by Mr. Carley says:

> "Although a prototype for many prepaid health plans exists at Marshfield, Wisconsin, the development of these plans elsewhere in the state has been slow and on a small scale. As a result, Wisconsin lacks the empirical evidence of large scale experimentation upon which to judge the effectiveness of this approach aimed at improving the scope and quality of health care."

Mr. Carley proposed that an experimental plan in Dane County would help add to this evidence. Dane County was chosen because most state employees live there and provide an easily accessible group to which the plan could initially be offered. However, the plan would be open to all Dane County residents.

The Dane County Medical Society is now poised to begin an experimental health maintenance plan. WPS (Wisconsin Physicians Service), which is handling the plan at the Dane County Society's request, is completing enrollment of physician participants in the experiment and hopes to finish enrolling interested groups this month. Because the plan is experimental, only current WPS groups are eligible and a limit of 15,000 individuals can participate.

According to Ray Koenig, WPS executive director, after the plan has run for a year it will be evaluated. On the basis of that evaluation, the plan may be continued, changed, or dropped.

WPS has plans of a similar nature in operation elsewhere in Wisconsin—at Wild Rose, and through the county medical societies in Pierce–St. Croix, Green and Richland Counties.

Health Task Force Doesn't Plan to Have Its Efforts Shelved

What happens when the Health Task Force self-destructs at the end of the year?

Task Force Chairman David Carley is determined that the ultimate result NOT be "a report that will lie on shelves of this state government for the next decade or two."

Much of what WILL happen will be determined by the fate of the Governor's Health Policy and Program Council headed by Ben Lawton, MD, Marshfield. This body was set up at the same time as the Health Task Force and also by an Executive Order. That order called for the Program Council to oversee five state health agencies which have federal funding: comprehensive health planning, developmental disabilities, hospital construction, mental health centers construction, and facilities for the mentally retarded. In order to insure that the Program Council does not disappear at the end of Governor Lucey's term, the Task Force is hammering out a more permanent organization to be established by law.

At the Task Force's August meeting, there was some confusion and a bit of alarm over the proposed organization of the Health Policy and Program Council.

"A two-headed monster" is what George Handy, MD, State Health Officer, predicted would result if some of the proposals were enacted.

He was referring to the proposed severing of Wisconsin's comprehensive health planning agency ("A" agency) from the

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Update on Work Groups

In the two months since the GREEN SHEET last took a look at the many projects being tackled by the Task Force, many of them have moved ahead significantly. Here, again, is a brief rundown of where projects now stand, listed by Task Force Work Groups.

Personal Health Services. A weighty paper issued by this work group (more than 100 pages) sets down "Guidelines for an acceptable Health Care System." The "Health Care System" with which the paper is concerned is the delivery of services to the general population. It deals with such problems as abortion, contraception, and family planning but not education, environment, quackery, and other aspects that affect the total health care system.

The paper defines acceptable community health care in such terms as convenience to patients and equal distribution of the costs involved.

The guidelines were drawn up after discussions with providers and consumers. In August the Task Force approved release of the paper for further discussion. Suggestions are still being received from interested groups. In October the Task Force will be asked to put its stamp of approval on the guidelines. After this happens, they will be forwarded to groups charged with seeing that they are implemented. These include the Health Policy and Program Council, areawide planning agencies ("B" agencies), the executive and legislative branches of state government, and state agencies.

Health Services Research and Development. Latest from this work group is a suggestion that the University of Wisconsin and the Wisconsin Regional Medical Program set up a way to develop and test ideas for solutions to Wisconsin's health delivery problems in all aspects. Costs appear to be estimated at from $60,000 to $150,000 per year. At its October meeting the Task Force will be asked to formally recommend these projects.

Health Financing. This work group's efforts on a proposal to provide health insurance to the uninsured are reported elsewhere in this issue of the GREEN SHEET.

This group is also trying to get a handle on Medicaid so the state can more closely control it. Current problems with Wisconsin's Medicaid Program include its use primarily for mental hospitals and nursing home patients, alleged inadequate cost controls, and a lack of any real impact on the health care services to the poor, which is the stated interest of the Medicaid legislation.

The work group proposes to expand Medicaid so that it reaches more people in a better way. The Task Force has already endorsed proposed legislation which would permit Medicaid recipients to enroll in prepaid programs. (This idea was endorsed by the State Medical Society's House of Delegates in its special session last October.) The work group also proposes emphasizing broad scale peer review of the care being received by and provided for Medicaid recipients. Final Task Force action will be asked in October.

This work group is also concerned with spending for mental health facilities. A story elsewhere in this GREEN SHEET deals with recommendations on "home rule" at the county level of state monies for mental health and alcoholism services.

Transportation. A mammoth, $1,250,000 grant to the Wisconsin Regional Medical Program (WRMP) to implement an emergency medical service (EMS) system was described in the July GREEN SHEET and in TRENDS in the July WISCONSIN MEDICAL JOURNAL.

At its August meeting the Task Force proposed that all Wisconsin citizens be assured emergency ambulance service and that legislation be drawn up to empower the state Department of Health and Social Services (DHSS) to make rules on this service. The proposal also calls for the DHSS to establish a system classifying hospitals according to the emergency medical services they offer.

Assuring ambulance service will not be easy and may possibly result in the elimination of the private ambulance business, this work group noted. The Transportation Work Group plans to put together a paper on alternative methods of financing emergency ambulance service.

The Task Force is coordinating its legislative efforts in this area with the WRMP's EMS people and with the Governor's Safety Coordinator.

The State Medical Society's Commission on Hospital Relations and Medical Education has been assigned responsibility to work with state departments and WRMP on the total subject. This portion of the Task Force report has been accepted in principle by the State Medical Society.

Health Education of the Public. "A vacuum in health education exists in state government." This is the view of Milwaukee labor leader Robert Durkin, a member of this work group which presented the Task Force with a proposal to establish a statewide system of health education.

This proposal accepts a proposition long espoused by Wisconsin and American medicine—that education of the public on health and health care is not solely a physician responsibility.

The health education system as proposed would be established within the Health Policy and Program Council. It would provide leadership at the state level for all health education efforts, including school health education.

Under the statewide committee on health education, would be regional health education committees established within "B" (areawide) comprehensive health planning agencies. These committees would coordinate all regional and local programs in health education, including school health education.

Thus, many public and private forces would be teamed to bring better health education to the public. The State Medical Society's Division on School Health and Commission on Health Information are being kept informed of this proposal

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Propose to Systematize Continuing Education on Statewide Basis

Like motherhood and apple pie, continuing education is popular with almost everyone. And, like motherhood, the main question seems to be how best to achieve it.

A Health Task Force proposal now at the discussion stage would systematize continuing education in the health fields on a statewide basis. In line with the Task Force's commitment to local "home rule" wherever possible, regional continuing education committees would be formed to do this. These would be made up of

> "individuals from local educational, planning, and provider bodies. This would include groups such as Comprehensive Health Planning (B) agencies, regional extension representatives, local vocational representatives, hospital designees, and public representatives."

If the Task Force goes ahead on this proposal (as it seems likely to do), more specific proposals will outline a way to organize health education statewide. The AHEC idea (see July WISCONSIN MEDICAL JOURNAL) will be the vehicle to do so and the "B" planning agencies will provide the manpower. Challenge exams have been mentioned as one way to police the quality of an individual's continuing education.

The Task Force is also discussing a way to have a central information source for all continuing education programs within the state. Many health educators take an "I'll believe it when I see it" attitude here, because these programs have been proliferating like coat hangers. Again, this would be handled by the "B" planning agencies.

The third facet of this proposal is evaluation of continuing education programs to see if they're doing any good. This is pegged for the Health Policy and Program Council, headed by Ben Lawton, MD, Marshfield.

The total continuing education package is slated for final Task Force approval in October.

Gov. Lucey Suggests Reorganizing DHSS

Reorganizing the state Department of Health and Social Services may be necessary in the near future, according to a June 29 letter Governor Lucey sent to that department.

In a message on 1973–75 budgeting, the Governor stressed that a major health issue for the rest of his current administration will be expansion of community-based treatment programs and a reduction in institutional programs and costs. The other major theme for that department is improving the delivery of social services and aids by better administrative organization, according to the Governor.

The community approach to state health administration, the Governor said, would mean the Department of Health and Social Services would need to be reorganized, basing it around the "neighborhood comprehensive social service center." He said "such a structure would facilitate maximum use of federal, state and local resources, provide a focal point for planning and delivering a comprehensive range of services as needed, and assure a single point of contact and accountability to those seeking services, as well as for the general public."

The Governor said "some funds presently supporting state institutions should be transferred to finance new expanded community-based programs."

To do this, he asked the department to decide how to phase out four state institutions: the Wisconsin Child Center at Sparta, Central State Hospital at Waupun, Wisconsin Home for Women at Taycheedah, and Wisconsin State Reformatory at Green Bay. Other state institutions may also be studied for phase out.

Health Task Force Doesn't Plan . . .

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Department of Health and Social Services and placing it in the Program Council or the Governor's office.

Because this is so controversial, it was not acted on when first discussed by the entire Task Force in August. Plans now call for it to be taken up at the October meeting.

Drafters of the Program Council's proposed structure would like to see it be the key policy body in Wisconsin for all health care planning, organization, administration, and delivery. This would mean no governmental offices or agency could get to the Legislature without consulting the Health Policy and Program Council.

Of the 45 members on the Program Council, only one would be specifically identified as an MD (for the medical profession), although other MDs might be named in such capacities as representing the Veterans Administration, Wisconsin Regional Medical Program (WRMP), third party payors, and the like. Program Council members would be selected to represent the state's population by geography, economics, race, sex, and age as well as the interests of government, consumers, and health care groups.

Update on Work Groups

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and their recommendations are being sought.

Developmental, Behavioral, and Chronic Problems. The public drunk would no longer be a criminal under a proposal presented by this subcommittee. The proposal asks that public drunkenness "be treated appropriately as a health problem." Legislation to this effect is now being drafted for Task Force approval.

Members of the subcommittee noted that a drunk who causes trouble could still be arrested on disorderly conduct or other charges.

Reported elsewhere in this GREEN SHEET are recommendations by this subcommittee on "home rule" at the county level of state monies for mental health and alcoholism services.

"Chain Letter" Approach to Help Racine MDs Identify Drug Abusers

A "chain letter" approach alerting Racine physicians to suspected abuse of prescription drugs has been set up by the Racine County Medical Society.

The "drug abuse incident alert" is to deal with people who make the rounds of physicians' offices seeking prescriptions for certain drugs.

An example of how the new program works is the case where a person comes to the physician's office and asks for a prescription because his regular MD is on vacation. After refusing to issue the prescription, the physician calls a local clinic named as the center of the program. The clinic staff then notifies local Pharmacy Control and two local physician groups. Each physician group in turn notifies two designated physician offices. As the chain expands, all physicians are quickly alerted to the incident.

The system is also connected to local pharmacies. In cases where the stores suspect a drug abuser, they tell local Pharmacy Control, which then notifies the designated central clinic. The same sequence in the chain is then followed.

Racine County physicians are also encouraged to develop a system in their offices to secure such identifying characteristics as the license number and color of the automobiles driven by suspects.

Dr. Frank L. Weston Honored for Service to Selective Service

Frank L. Weston, MD, Madison, was honored by the Wisconsin Selective Service August 8 for his long service as chairman of the Wisconsin Selective Service Medical Advisory Committee on medical, dental and veterinary registrants.

Dr. Weston

Dr. Weston was presented the Selective Service Silver Medal for Exceptional Service by state Selective Service director Robert Levine. Dr. Weston has been chairman of the state volunteer medical advisory committee since it was started in 1950.

In making the award, Mr. Levine cited Dr. Weston for receiving "both the respect and the full cooperation of his committee" and for being "instrumental in achieving a delivery record for Wisconsin, unsurpassed by any other state."

Dr. Weston is treasurer of the State Medical Society.

Medical Education Curricula to Be Studied by MCW

"Curriculum Change: Fad or Necessity?" is the topic of the Medical College of Wisconsin's second annual symposium on issues confronting medical educators. The program will be held October 7–8 at the Ramada Inn in Waukesha.

Speakers include L. Thompson Bowles, MD, PhD, Director of the Division of Curriculum and Instruction, Association of American Medical Colleges, and Kenneth Endicott, MD, Director of the Bureau of Health, Education and Manpower Training, National Institutes of Health.

Topics include new ideas and status reports on medical school curricula nationwide and the use of programmed instruction and audio-visual aids.

Dr. Schmidt Named to Society's CMCP

Daniel K. Schmidt, MD, Mequon, has been named to the State Medical Society's Commission on Medical Care Plans. The Commission, which includes both physician and nonmedical members, directs the Society's WPS-Blue Shield Plan, as well as other health care programs including Medicare and Medicaid.

Dr. Schmidt, a family physician, is a native of Milwaukee and a 1951 graduate of Marquette University School of Medicine. He has practiced in Milwaukee since completing his internship at Milwaukee's St. Joseph's Hospital in 1952.

He has served as chairman of the St. Joseph's Hospital Department of General Practice and vice-chief of staff. He is a charter diplomate of the American Board of Family Medicine.

Since 1970 Dr. Schmidt has been a member of the State Medical Society's Council. He has also served as secretary-treasurer of The Medical Society of Milwaukee County.

Donald J. McIntyre

Society Names Full-Time Legislative Counsel

Starting October 1, Donald J. McIntyre, assistant insurance director of WPS-Blue Shield, will become the full-time legislative counsel for the State Medical Society.

Mr. McIntyre will direct the Society's legislative activities, a particularly demanding responsibility with the Legislature going to annual sessions starting in January.

Consulting legal counsel retained by the Society will continue to provide assistance on bill drafting and analysis.

Mr. McIntyre obtained his law degree from the University of Wisconsin in 1951 and spent 15 years with Rural Mutual Casualty and Threshermen's Mutual Insurance Companies in the Milwaukee and Fond du Lac areas. He came to the Society as WPS assistant claims director in 1966 and since then has held a series of positions including director of government programs. His most recent duties have included supervision of the health maintenance programs of WPS.

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'Stimulating' Summer for MECO Students and MDs

"Satisfactory in all respects" . . . "stimulating" . . . "kept me on my toes"—these are some of the comments Wisconsin physicians had on this summer's MECO program in Wisconsin.

MECO (Medical Education–Community Orientation) is a summer work-study program designed to give the preclinical student the opportunity to be involved in all aspects of activity in the physician's office and the hospital.

The Student American Medical Association (SAMA), which sponsors MECO, this year assigned 22 medical students to Wisconsin towns. All were students at Wisconsin medical schools but one—a University of Illinois Medical School student who wanted to see medicine as practiced outside the big city hospital.

Some of the physicians who participated in the program said:

- "I think (the student) learned a lot about community medicine."
- "The program is almost of equal benefit to the staff physicians and the other staff of the hospital in that it is stimulating and challenging to have a student about, thus encouraging more self education."
- "This boy lived in my home for the summer and it was quite refreshing to hear his comments at the end of the day. The experiences that he had during the day very often caused some searching through my library looking at various texts, looking up various diseases."

The consensus seems to be that everyone benefited from the program—students, physicians and hospital staffs. A frequent comment by physicians was that perhaps the program went so well because the student assigned to that community was particularly outstanding.

Under State Medical Society cosponsorship, the MECO students worked some 40 hours each week under the direct supervision of a physician. It is hoped that in addition to being a learning experience for the student, MECO will result in attracting more physicians to the primarily non-urban areas where the students are assigned. About 70 percent of the students taking part in the MECO program since it was first begun in Illinois in 1969 have indicated they hoped to return and practice in the community that sponsored their MECO experience.

Wisconsin was one of 18 states participating in MECO last year. This year there are 40 states in the program. In addition to the State Medical Society, cosponsors of MECO are the Wisconsin Hospital Association and the Wisconsin Chapter of SAMA, representing Wisconsin's two medical schools. The communities where the students are assigned provide a $775 stipend to each student.

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NEWS HIGHLIGHTS

Lake Shore Medical Building

. . . in Kenosha has recently been completed adjacent to St. Catherine's Hospital. Constructed at a cost of about $547,000, the new medical center includes 17 doctors' suites, three of which are now occupied. An underground tunnel connects the medical center with the hospital and facilitates use of the hospital laboratories and pharmacy. The building's first occupant was George C. Schutle, MD,* in February, followed by Blair T. Bonell, MD,* and most recently Ernesto E. Buencamino, MD who moved to Kenosha from Milwaukee. The medical center was financed by St. Catherine's, but it is a separate entity which is subject to local taxes, according to Sister M. Dolorosa, the hospital's administrator.

Wisconsin Respiratory Care Society Names Adviser

Larry A. Lindesmith, MD,* internist at the Gundersen Clinic in La Crosse, has been named medical adviser for the Wisconsin Respiratory Care Society (WRCS). The Society was organized in February by a small group of nurses, who, in 1955, originally formed the interorganizational committee for tuberculosis nursing. It now has about 50 members, consisting of pulmonary nurses, respiratory therapists, physical therapists, occupational therapists, educators, and qualified resource persons. The WRCS serves as a paramedical arm of the Wisconsin Tuberculosis and Respiratory Disease Association, and, through the Wisconsin Thoracic Society, develops, endorses, and promotes an interprofessional system of respiratory care for state residents. The WRCS meets quarterly, with the next meeting scheduled for October at the Gundersen Clinic–Lutheran Hospital, La Crosse.

Wisconsin Academy of Family Physicians Meets

Richard W. Shropshire, MD* of Madison was installed as president of the Wisconsin Academy of Family Physicians during its Congress of Delegates' annual session at the Hoffman House–Midway Motor Lodge in Wausau July 15.

William E. Hein, MD* of Monroe was elected president-elect; Nicholas F. Damiano, MD* of Hales Corners was reelected secretary–treasurer of the Academy. Leonard B. Torkelson, MD,* Baldwin, was elected speaker of the Congress of Delegates and Donald J. Heyrman, MD,* Menomonee Falls, was named vice-speaker.

New members of the board of directors are MDs Rocco Galgano,* Delavan, and John O. Grade,* Elm Grove. Paul E. Wainscott, MD,* Menasha, outgoing president of the Academy, was elected chairman of the board. Reelected to the board were MDs Theodore C. Fox,* Antigo, and Merne W. Asplund,* Bloomer. Holdover members of the board include MDs Richard K. Chambers,* Hartland; John U. Peters,* Fond du Lac; James N. Moore,* Madison; Henry C. Rahr,* Green Bay; and Robert F. Purtell, Jr.,* Milwaukee.

MDs Charles J. Picard,* Superior, and Wendell D. Hamlin,* Mineral Point, were reelected delegate and alternate delegate, respectively, to the American Academy of Family Physicians.

Actions of the Congress of Delegates included passage of a resolution urging the development of family practice residencies in parts of the state besides St. Michael Hospital in Milwaukee and University Hospitals in Madison, a resolution urging the Medical College of Wisconsin to continue its efforts to set up a family practice residency program which would be set up as a full department headed by a family physician, and a commenda-

PHYSICIAN BRIEFS

Bruce C. Kirkham, MD*

. . . Eau Claire, recently was named staff radiologist at Sacred Heart Hospital, Eau Claire. A graduate of the University of Wisconsin Medical School, Doctor Kirkham was previously chief of radiology for the U.S. Public Health Service Hospitals of New Orleans.

Paul F. Dvorak, MD*

. . . Madison, recently was elected a fellow in the American Academy of Pediatrics.

Pedro B. Fernandez, MD

. . . Sheboygan, recently joined the Sheboygan Clinic in the Department of Obstetrics and Gynecology. A graduate of the Far Eastern University, Manila, The Philippines, he completed his internship at Evangelical Deaconess Hospital, Milwaukee, and his residencies at Norwegian–American Hospital, Chicago, and the Scott and White Clinic, Temple, Tex. Prior to joining the Sheboygan Clinic, he had been in private practice and served as a house officer in the Department of Obstetrics and Gynecology at Mount Sinai Medical Center, Milwaukee. Doctor Fernandez also is serving as an examining physician for the United Migrant Opportunity Services in the Sheboygan area.

Donald J. Ryan, MD*

. . . Neenah, and Paul E. Wainscott, MD,* Menasha, recently were reelected president and vice-president, respectively, of the Theda Clark Memorial Hospital. Robert E. Dedmon, MD,* was named secretary.

Edward J. Lennon, MD*

. . . of the department of medicine, Medical College of Wisconsin, Milwaukee, is principal investigator of a $121,648 grant from the US Public Health Service for radiation therapy research.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Loren F. Thurwachter, MD*

. . . Milwaukee, was recently named president-elect of the Wisconsin Medical Alumni Association. He is a 1945 graduate of the University of Wisconsin Medical School and has been a director of the alumni association for the past three years. He will take office on Alumni Day in 1973.

James T. Houlihan, MD

. . . Minocqua, recently became associated with Lakeland Medical Associates, Inc. A graduate of Stritch School of Medicine, Loyola University, Chicago, Doctor Houlihan practiced in Chicago and Evergreen Park, Ill., for 25 years. He served in the United States Army Medical Corps during World War II and was on the medical staff of Little Company of Mary Hospital in Evergreen Park. Doctor Houlihan also is on the staff of Lakeland Memorial Hospital, Minocqua.

Barry J. Seidel, MD

. . . Minocqua, recently became associated with Lakeland Medical Associates, Inc. He is a graduate of Marquette University School of Medicine (now The Medical College of Wisconsin) and served his internship at Milwaukee County General Hospital prior to taking the four-year residency at The Medical College of Wisconsin affiliated hospitals.

Charles Dais, MD

. . . Green Bay, recently became associated with the pathology department at St. Vincent Hospital, Green Bay. Doctor Dais graduated from the University of Tennessee Medical School and completed his pathology residency at Baptist Memorial Hospital, Memphis, Tenn. While at the University of Tennessee Medical School, Doctor Dais lectured in biochemistry and received the Teacher of the Year award from the School of Nursing. He is a diplomate of the American Boards of Anatomic and Clinical Pathology.

tion to Henry Pitot, MD,* acting dean of the UW Medical School, for his work in developing the residency program there.

The Academy's Congress of Delegates also criticized Surgical Care–Blue Shield of Milwaukee for the way in which it sells group health insurance policies in some areas of Wisconsin, calling it "misleading and dictatorial." The resolution approved by the Academy states that the insurance company says that it will pay benefits according to the usual and customary fees charged in the community. However, the resolution further states that the company "arbitrarily established a usual-and-customary fee schedule in some counties, without sufficient physician consultation," and the published schedules are not the usual fees charged by the physicians. The resolution also condemned the practice of the insurance company of telling its policy holders not to pay fees in excess of their coverage. The resolution said the patient is responsible for payment, since it is the responsibility of the physician and not the insurance company to set fees.

The State Medical Society's immediate past president, George A. Behnke, MD* of Kaukauna was honored by the Family Physicians "for his dedication and service to the profession of medicine."

La Crosse Lutheran Hospital

. . . interns and residents now have a $530,000 housing complex which combines home and study hall near the hospital. Edwin Overholt, MD*, director of medical education at the Gundersen Clinic, says that most of the 31 interns and residents who constitute the house staff live in the new duplexes. The apartment setting has family living accommodations. The U.S. Department of Housing and Urban Development (HUD) gave the hospital a grant of $410,000, at three percent interest over 40 years, to construct the housing units. According to Jack Schwem, administrator, the HUD program usually deals with college housing, but the hospital's educational program qualified in this category.

Wisconsin Heart Aids La Crosse Rehab Plan

A special exercise program for heart patients and coronary-prone individuals in the La Crosse area has been funded by the Wisconsin Heart Association (WHA).

Support for the first year of the Cardiac Rehabilitation Program, which is the first of its kind in the La Crosse area and one of few in the country, amounted to $4,485. The grant was announced in July by WHA president, John H. Morledge, MD* of Madison.

The program is a function of the College of Health, Physical Education, and Recreation at the University of Wisconsin–La Crosse. Administrative heads are Robert McMahon, MD,* an internist at the Gundersen Clinic, who is chairman of the program's executive board, and Philip K. Wilson, an associate professor at the UW–L, executive director.

Oconto County Medical Society

A pilot project of nursing assessment of pre-school children was conducted in August under the direction of the Oconto County Medical Society. Registered nurses from the Oconto County Public Nurse office checked the children for possible vision and hearing problems, gave blood and urine tests and also cardiac tests. Where health deficiencies were noted, the child was referred to the family physician.

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George T. Anast, MD

. . . formerly of Chicago, recently became associated with Lakeland Medical Associates, Inc. in Minocqua. Doctor Anast had been in practice in the Chicago area since 1960. He received his medical degree from the University of Illinois College of Medicine, served his residency at Veterans Administration Hospital, Hines, Ill., Shriners Hospital for Crippled Children, and also served as a staff orthopedic surgeon for the United States Navy for two years.

Poderoso G. Prado, MD

. . . recently opened his medical office in Palmyra. Prior to locating in Palmyra, Doctor Prado had been the chief resident at St. Michael's Hospital, Milwaukee, where he had been affiliated since 1968. He is a graduate of Santo Tomas University School of Medicine, Manila, The Philippines.

Derek J. Cripps, MD*

. . . Madison, professor of medicine, recently was named chief of dermatology at University Hospitals, Madison. Doctor Cripps is a graduate of the University of London Medical School in 1953 and took a residency in dermatology at the University of Michigan. He has been on the medical staff at University Hospitals since 1965. He succeeds Sture A. M. Johnson, MD* who retired.

Francis F. Rosenbaum, MD*

. . . Milwaukee, recently was granted Fellowship in the American College of Cardiology (ACC). This membership classification qualifies him as a specialist or consultant in cardiovascular diseases.

Ki J. Whang, MD

. . . Beaver Dam, recently opened his office in the Beaver Dam Medical Center in the specialty of urology. Prior to coming to Beaver Dam, Doctor Whang was in Iowa City, Ia., where he completed his residency at the University of Iowa.

Children's Diagnostic Clinic Opens at University Hospitals

On July 11 a new diagnostic clinic for children at University Hospitals opened according to Superintendent James W. Varnum. This clinic provides a setting for the diagnosis of perceived illness and makes provisions for management and continuing care for the children seen by clinic staff.

Clinic director Peter Karofsky, MD will be joined by resident physicians and the clinical faculty of the University of Wisconsin Center for Health Sciences. Full social and nursing services will be provided and extensive laboratory, radiological and consulting services will be immediately available.

Referrals to the clinic may come from any source: local physician, public health nurse, teacher, school nurse, social worker, or parent.

Treatment and consultation will be on Tuesdays from 8 a.m. to noon. All patients' families will be contacted prior to the visit for introduction to the service and accumulation of pertinent information.

The local physician will be contacted by Dr. Karofsky or another physician as soon as possible after a diagnosis has been made and management begun.

Referrals or questions about the clinic should be directed to Mrs. Virginia Dykstal, RN, at the Pediatric Specialty Clinics, 1552 University Ave., Madison 53706, or by calling (608) 262–4882.

Mental Health Leadership Institute Set

The Wisconsin Association for Mental Health will hold its 15th Annual Leadership Institute October 18–20 at the Marc-Plaza Hotel (formerly Sheraton–Schroeder Hotel) in Milwaukee. The convention combines WAMH business with training and educational sessions for citizens and professionals.

Addressing the convention on October 19 will be the president of the National Association for Mental Health, Irving Chase of Boston, Mass. A retired US Navy Rear Admiral and presently chairman of Henry Thayer Industries, Mr. Chase will talk about national trends and directions in the delivery of care to the mentally ill. His participation will mark the first time that a NAMH president has spoken in Wisconsin.

Gov. Patrick J. Lucey will keynote an awards luncheon on Friday, October 20. The Governor has been asked to clarify and expand upon his plans and the plans of the state Health Planning Council as they relate to the future mental health delivery system in Wisconsin.

In addition to the two general sessions during the three-day meeting, 35 workshops will be offered. The disadvantaged, grief and death, psychiatric nursing, pre-retirement programs, parent power, clergymen and mental health, living with teenagers, the mid-life crisis, and the law and mental health are among a wide variety of subjects which will be discussed by qualified leaders in the workshops. The theme for the 15th annual convention is "The Right to Know." A heavy emphasis will be placed this year on the involvement of parents in learning about mental health practices.

The convention is open to the public and over 400 citizens and professionals are expected to attend. A registration fee of $5 covers the cost of all materials and coffee breaks. The luncheon on October 20 is extra and costs $4.50. Advance registration is suggested with WAMH, P. O. Box 1486, Madison, Wis. 53701.

Dr. John Wear Completes SS Hope Duty

John B. Wear, Jr., MD* of Madison recently completed a two-month tour of duty aboard the SS HOPE in Natal, Brazil. He is professor and chairman of the Section of Urology, Department of Surgery, University of Wisconsin Medical Center.

Doctor Wear is believed to be the first urologist from Wisconsin to ever serve on board the SS HOPE. His account of the experience follows:

"The mission of the SS HOPE is primarily that of education of physicians, nurses, and paramedical personnel in medically deprived areas of the world. This was particularly the case in Natal, Brazil, where the infant mortality is over 50%, malnutrition is extremely prevalent, and parasitic infestation (with 3 or 4 parasites) is present in the vast majority of the lower class of people in this area.

"My tour of duty was from April 13 to June 16, 1972, and this represents probably the most rewarding and satisfying two months of my life. I was extremely fortunate in working with a very well trained urologist, Dr. Joao Cabral, who is Chief of Urology at the local medical school in Natal. He was quite honest about his major deficiencies in the area of transurethral surgery and pediatric urology. Accordingly, most of my time was spent training him in these two areas, while simultaneously providing appropriate urological care to the Brazilian people.

"About half of our urological surgery was performed on board the ship, and the other half was performed at a local indigent hospital. The people on board the ship, as a group, were the most dedicated, pleasant, and efficient nurses and paramedical personnel that it has ever been my fortune to work with. I can heartily recommend this experience to anyone who is able to leave his medical practice for a period of two months. In 1973, the SS HOPE will again return to Brazil, although it will serve some other city in the northeastern area."

In her twelve-year history, the hospital ship has visited ten countries on four continents, each for a period of ten months. When the SS HOPE returns to Brazil next year, it will be the first time the ship has extended her mission into a second voyage to a country. The Department of Information Services, Project Hope, Washington, D.C. 20007, welcomes the opportunity to send information to any interested physician.

Society's Eleventh District Has Annual Meeting

Physicians in the State Medical Society's Eleventh Councilor District met August 9 at the Madeline Island Country Club near Ashland. The scientific program was presented by Gloria Sarto, MD,* of the Department of Obstetrics–Gynecology, University of Wisconsin Medical Center, and J. M. Hardacre, MD* of the Marshfield Clinic. Doctor Sarto spoke on "What's New in Genetics" while Doctor Hardacre discussed "Surgical Management of Peptic Ulcers." The State Medical Society president, Robert F. Purtell, MD* of Milwaukee and the Council chairman, Eugene J. Nordby, MD* of Madison were present as well as the Eleventh District councilor, Thomas J. Doyle, MD* of Superior. J. M. Jauquet, MD* of Ashland was in charge of arrangements.

Wisconsin MDs Become Certified Anesthesiologists

MDs Mohini K. Raisinghami* of Wood and Harry E. Thimke* of Eau Claire recently were certified as Fellows of the American College of Anesthesiologists. MDs Peter Lameka, Jr.* of Milwaukee and Ivo Pecina* of Wood recently were certified as Diplomates of the American Board of Anesthesiology. □

Lester J. Bayer, MD*

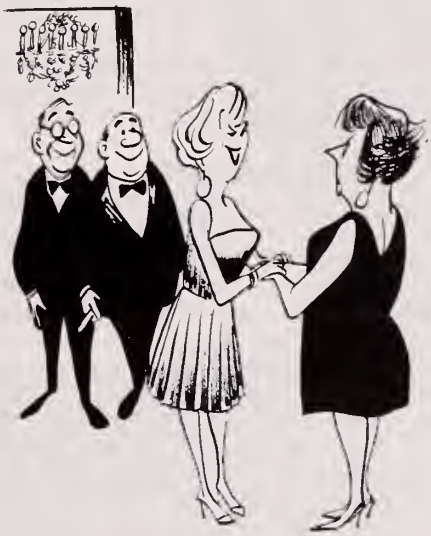
. . . Merrill, recently was honored at a reception at Holy Cross Hospital, Wausau, for his 40 years of medical service in Merrill. He graduated from Northwestern University Medical School and joined his late father, William H. Bayer, MD in 1932, in the practice of medicine.

Derward Lepley, Jr., MD*

. . . Milwaukee, will participate in the program of the American College of Chest Physicians at its Annual Scientific Assembly in Denver October 24–26. He will discuss "Modern Approach to Coronary Artery Disease."

Harry R. Weil, MD*

. . . Milwaukee, recently was elected secretary of the North Central Region of the American Association for Clinical Immunology and Allergy.



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Dean B. Pratt, MD

. . . Sheboygan, recently joined the medical staff of the Sheboygan Clinic. Doctor Pratt graduated from the University of Minnesota Medical School and served his internship at Hennepin County General Hospital, Minneapolis, Minn. He served in the United States Army Medical Corps and recently completed a five-year residency at Hennepin Hospital in the field of vascular surgery. He is on the medical staff of Sheboygan Memorial and St. Nicholas hospitals, Sheboygan.

Glicerio Rufino, MD

. . . recently opened his office in Oconto and was admitted to the medical staff of Oconto Memorial Hospital. Doctor Rufino graduated from the University of Santo Tomas, Manila, The Philippine Islands, and served his internship at St. Michael's Hospital, Milwaukee. He completed his residencies at St. Michael's and Deaconess hospitals, Milwaukee, and the Norwegian American Hospital, Chicago.

Karl Aldinger, MD

. . . Stevens Point, recently became associated with the Rice Clinic in the Department of Ophthalmology. He graduated from the University of Iowa Medical School and completed his internship at Good Samaritan Hospital, Portland, Ore. He served in the United States Navy for two years and took his residency at the University of Texas Southwestern Medical School in Dallas, Tex.

Brigido Calado, MD

. . . Watertown, recently opened his office for the practice of pediatrics. He graduated from the University of the Philippines in Manila and took special pediatric training at the Philippine General Hospital. He served his internship at Deaconess Hospital, Milwaukee, and completed his residency at Milwaukee Children's Hospital. He is on the medical staff of Watertown Memorial Hospital.

John T. Campbell, MD

. . . Menasha, recently joined the staff of the Riverside Clinic. A fellow in urology at the Mayo Clinic, Doctor Campbell graduated from Case Western University and served his internship at Queen's Hospital, Honolulu, Hawaii. He had been at the Mayo Clinic since 1969.

David V. Foley, MD*

. . . Wauwatosa, recently was elected chairman of the Department of Obstetrics and Gynecology of St. Joseph's Hospital, Milwaukee. He has been on the medical staff since 1958. Doctor Foley also is an assistant clinical professor in obstetrics and gynecology at the Medical College of Wisconsin.

Frederick S. Brightbill, MD*

. . . Madison, recently joined the staff of the Davis–Duehr Eye Associates. A graduate of the University of Illinois Medical School, he served his internship in Denver, Colo., and trained at the Mayo Clinic, Rochester, Minn. Doctor Brightbill also is an assistant clinical professor in the University of Wisconsin Medical School Department of Ophthalmology.

Michael G. O'Mara, MD

. . . Oconomowoc, recently opened his office for the practice of internal medicine. He graduated from the University of Oregon Medical School, served his internship at Santa Clara County Hospital, San Jose, Calif., and completed his residency at Milwaukee County General Hospital.

Harold M. Swartz, MD*

. . . of the department of radiology, Medical College of Wisconsin, Milwaukee, is principal investigator of a $171,195 grant from the John Hartford Foundation to study the clinical application of electron spin resonance spectroscopy. He will study tissues from patients and develop tests for early cancer detection and for evaluation of courses of treatment.

Resa Amin, MD

. . . Oconomowoc, recently joined the medical staff of the Wilkinson Clinic. A graduate of the Pahlavi University Medical School, Iran, he served his internship at St. Elizabeth's Hospital, New York, and completed two years of pediatrics residency at Cook County Hospital in Chicago. Prior to arriving in Oconomowoc, he completed a two-year fellowship in pediatric allergy at Milwaukee Children's and Milwaukee County General hospitals.

A. N. Chatterjee, MD

. . . Antigo, has joined the medical staff of General Clinic in the practice of family medicine and as a consultant in general surgery. Doctor Chatterjee obtained his medical degree in India and was a resident in surgery in Calcutta from 1959–1961. He moved to England and was trained in general surgery, orthopedics, and urology. He obtained his fellowship in the Royal College of Surgeons of Scotland and of England in 1968.

Richard D. Stewart, MD*

. . . of the department of environmental medicine, Medical College of Wisconsin, Milwaukee, is the principal investigator of a $375,000 grant from the National Institute for Occupational Safety and Health to develop biological standards for the industrial worker by breath analysis.

William F. Bingham, MD

. . . La Crosse, recently joined the Department of Neurosurgery of Gundersen Clinic Ltd. and La Crosse Lutheran Hospital. Doctor Bingham graduated from Jefferson Medical College, Philadelphia, and served his internship at Yale–New Haven, Conn., hospital. He served in the United States Navy as general duty officer and completed his residency training at the Neurological Institute of New York and Columbia Presbyterian Medical Center in New York City.

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PHYSICIAN BRIEFS . . .

Rodolfo Molina, MD*

. . . Beaver Dam, a member of Consultant Physicians in Pathology, Beaver Dam Community Hospitals, recently was recognized as a certified specialist with special competence in all aspects of the diagnostic, therapeutic, and medical research uses of radioactive materials. The announcement was made by Merrill A. Bener, MD, chairman of the American Board of Nuclear Medicine, Inc.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1972

2 Dane County Medical Society Long Range Planning Committee
3 SMS Ad Hoc Committee on Chiropractic
9 Board of Directors, Wisconsin Health Council
11 Executive Committee of SMS Council
12 Board of Trustees, Interstate Postgraduate Medical Association
16 Board of Trustees, SMS Realty Corp.
21 Program Committee, Wisconsin Health Council
30 SMS Commission on Health Information
31 SMS Committee on Peer Review

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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PHYSICIAN BRIEFS . . .

William A. Kisken, MD*
Kermit L. Newcomer, MD*

. . . La Crosse physicians associated with the Gundersen Clinic, recently presented papers at the second annual meeting of the North Central Dialysis and Transplant Society. The Gundersen Clinic has been involved in kidney research since 1968 and the program is supported by the Adolf Gundersen Medical Foundation and Lutheran Hospital.

Paul Rice, MD

. . . West Bend, recently became associated with W. E. Scheunemann, MD,* West Bend, in the practice of ophthalmology. A graduate of the University of Illinois College of Medicine, he served his internship at the University of Tennessee in Memphis and his residency at the University of Illinois Eye and Ear Infirmary in Chicago.

John A. Welsch, MD

. . . Fond du Lac, recently became associated with Bruce Hartman, MD,* in the practice of orthopedic surgery. He graduated from Marquette School of Medicine and interned at the Los Angeles County General Hospital. He also served with the USAF Medical Corps and attended the Mayo Graduate School, Rochester, Minn.

David H. Zarwell, MD

. . . La Crosse, recently joined the medical staff of St. Francis Hospital, La Crosse. A graduate of the University of Wisconsin Medical School, Doctor Zarwell is associated with Edward S. Orman, MD* at the La Crosse County Guidance Clinic.

Robert H. Kitzman, MD

. . . Rhinelander, recently became associated with the Bump Medical Group, Rhinelander. He graduated from Marquette School of Medicine and served his internship at St. Joseph's Hospital, Milwaukee. Doctor Kitzman served in the United States Air Force and graduated from the Milwaukee orthopedic residency program.

Robert H. Caplan, MD*

. . . Gundersen Clinic, Ltd. and La Crosse Lutheran Hospital, recently was presented the Lutheran Hospital's Outstanding Teacher Award for 1972. The award is given annually to the doctor who has contributed the most to the residents' and interns' education. □

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JULY 19, 1972

NEW MEMBERS

Choudhri, Fiaz A., 400 East Thomas St., Wausau 54401
McKelvey, M. A., Box 50, Hidden Meadows, Route #2, Watertown 53094
Mobarek, Yousef S., 5000 W. National Ave., Wood 53193
Odulio, Teofilo O., 400 East Thomas St., Wausau 54401
O'Grady, Michael G., 2500 West Lincoln Ave., Milwaukee 53215
Parcon, Jazmin D., 2388 North Lake Dr., Milwaukee 53211
Perez, Celestino M., 114 South 4th St., Watertown 53094
Prieto, Albert, 615 South 10th St., La Crosse 54601
Ramesh, K. G., 3600 Tower Ave., Superior 54880
Scherman, Francis G., 2320 North Lake Dr., Milwaukee 53211
Schoenecker, Edgar A., 5000 West National Ave., Wood 53193

CHANGE OF ADDRESS

Argand, Robert, 205 North Prospect, Madison 53705
Aughenbaugh, David K., 400 East Thomas St., Wausau 54401
Awen, Charles F., 744 South Webster Ave., Green Bay 54301
Balliet, Charles M., 400 East Thomas St., Wausau 54401
Brueggmann, James, 8119 Golden Forest Dr., San Antonio, Tex. 78239
Burr, Thurl C., Jr., 400 East Thomas St., Wausau 54401
Cappaert, William E., 2591 Guilford, Cleveland Heights, Ohio 44118
Day, Kenneth L., 400 East Thomas St., Wausau 54401
DiRaimondo, Joseph C., 1636 Miriam Rd., Manitowoc 54220
Ender, Carl A., Route #1, DeSoto 54624
Fechtner, Harold H., 400 East Thomas St., Wausau 54401
Hammes, George R., 726 Spring St., Wausau 54401
Hoessel, Arthur W., 400 East Thomas St., Wausau 54401
Hoffman, William C., 1113 East Sumner, Hartford 53027
Hull, Stephen B., 1260 Greenway Terr., Apt. 4, Brookfield 53005
Huston, John, 3023 East Newport Court, Milwaukee 53211
Jolin, James L., P. O. Box 503, Milwaukee 53201
Kay, Eugene M., 3314 South Oneida Way, Denver, Colo. 80222
Kelley, William B., 15865 Smith Dr., Brookfield 53005
Kim, Zaezeung, 4521 North Wildwood Ave., Milwaukee 53211
Klatt, Kenneth M., 20 South Park St., Madison 53715
Klieger, Jack A., 4910 West Burleigh St., Milwaukee 53210
Kontra, Dennis J., 5814 Washington Ave., Racine 53406
Kramer, James D., 400 East Thomas St., Wausau 54401
Kult, Anthony S., 2626 North 76th St., Milwaukee 53213
Landsberg, Manfred, 3067 South Superior St., Milwaukee 53207
Lane, Larry R., 1711 Lincoln Rd., Champaign, Ill. 61820
Larsen, Roy B., 400 East Thomas St., Wausau 54401
Leclercq, Toussaint, 3555 Berry St., No. 619, Montreal, Quebec, Canada
Lloren, Jose T., Jr., 245 East 2nd St., Fond du Lac 54935
Massart, John J., 4910 West Burleigh St., Milwaukee 53210
Matzke, Robert F., 2727 Woodlane Dr., Janesville 53545
Mitcham, LeRoy, 1255 North 22nd St., Milwaukee 53205
Molinaro, Albert J., 400 East Thomas St., Wausau 54401
Nock, Gilbert J., Jr., 11706 North Solar Ave., Mequon 53092
Nolasco, Thomas C., Jr., 19333 West North Ave., Brookfield 53005
Olsen, Arthur H., 1705 South 35th St., Milwaukee 53215
Paust, Joan C., Parc Verdone Deux, Apt. 434, Ruden Place, West Haven, Conn. 06516
Peterson, Thomas H., 400 East Thomas St., Wausau 54401
Prehn, Fred C., 3115—7th St., Wausau 54401
Quandt, Valerius V., 1113 East Sumner, Hartford 53027
Raisinghani, Mohini, 1804 South 59th St., Milwaukee 53214
Reeb, Kenneth G., 2103 Adelbert Rd., Cleveland, Ohio 44106
Rodgers, Richard E., 2040 West Wisconsin Ave., Milwaukee 53233
Schuele, David T., P. O. Box 188, Oconomowoc 53066
Shannon, Richard C., 922 McIndoe St., Wausau 54401
Sladky, James A., 5900 South Lake Dr., Cudahy 53110
Smith, Burton K., 400 East Thomas St., Wausau 54401
Spiegelhoff, Don R., 6286 Parkview Rd., Greendale 53129
Starkey, Thomas A., 400 East Thomas St., Wausau 54401
Tamayo, Primo R., 7807 North Chadwick Rd., Glendale 53217
Tyne, Lee M., 17050 West North Ave., Brookfield 53005
Viernes, Patricio F., 10425 West North Ave., Wauwatosa 53226
Wick, Henry O., Jr., D. O., 2945 South 126th St., New Berlin 53151
Zeps, Aivars A., 759 North Milwaukee St., Milwaukee 53202

DEATHS

Kwapy, Clemens R., Milwaukee County, June 16, 1972
McNamara, Thomas B., Barron–Washburn–Sawyer–Burnett County, June 20, 1972
Gruender, Jack E., Milwaukee County, June 23, 1972
Kundert, Elizabeth, nonmember, July 2, 1972

CORRECTION

In the June issue, Society Records section (page 52), a change of address was incorrectly reported for Don R. Spiegelhoff, MD. His address was reported as being changed to 9203 West Bluemound Road, Milwaukee. However, his address is unchanged and remains at 6286 Parkview Road, Greendale, Wisconsin 53129. □

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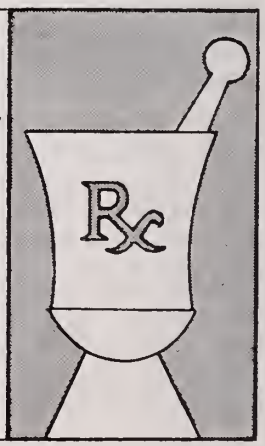

SECTION OPHTHALMOLOGY

SEPTEMBER 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

UW RESIDENTS COMPLETE TRAINING

Four residents completed three years of ophthalmology residency training August 31 at the University of Wisconsin Medical Center. Dr. James D'Amato moved to the state of Washington. Dr. Richard Appen went to Boston, Mass., to take a one-year neuro-ophthalmology fellowship. Dr. Richard Baske joined the Jackson Clinic in Madison. Dr. Sam Strickland went to Alabama to take a six-month fellowship in plastic surgery.

NEW OPHTHALMOLOGIST IN MADISON

Dr. Fred Brightbill has joined the Davis–Duehr Eye Clinic in Madison. He completed his ophthalmology residency at the University of Wisconsin in 1971. For the past year Doctor Brightbill has been at the University of Florida in Gainesville specializing in diseases and surgery of the conjunctiva and cornea. He also will teach at the University of Wisconsin part of the time.

ALUMNI DAY—SCIENTIFIC ABSTRACTS

The following abstracts are from papers presented at the Medical College of Wisconsin Alumni Day June 3:

Followup on Several Patients with Presumed Ocular Toxoplasmosis After Treatment, by ELISE TORCZYNSKI, MD:

Six patients with fundus lesions compatible with the diagnosis of toxoplasmosis were treated with steroids, photocoagulation, sulfa, daraprim, and folinic acid. Clinical material and followup were presented.

Fluorescein Study—Family with Angioid Streaks and Pseudoxanthoma Elasticum, by DAVID S. HULL, MD:

Two consecutive generations of a family with known angioid streaks were studied with indirect ophthalmoscopy, Hruby lens biomicroscopy, stereo color fundus photos, and fluorescein angiography. Four of five members of the first generation studied had angioid streaks. Three of seven members of the second generation studied showed early angioid streaks.

Three conclusions were drawn. (1) The second generation of this family, now in their late teens and early twenties, showed signs of early angioid streaks. (2) The genetic pattern in this family was probably dominant, and (3) Hruby lens biomicroscopy, indirect ophthalmoscopy, and stereo color fundus photos are superior to fluorescein angiography for the detection of early angioid streaks.

Experimental Herpes Simplex Ocular Infection in the Rabbit Model, by DAVID F. SWEET, MD:

Preliminary herpes simplex virus infections in the rabbit were reviewed. The pathogenesis of infection as it pertains to the rabbit model was discussed.

Experience at the Medical College of Wisconsin with Therapeutic Use of Hydrophilic Lens, by HENRY J. UTLEY, MD:

A variety of anterior segment ocular diseases were evaluated with regard to therapeutic response to the hydrophilic soft lens. A positive therapeutic response resulted in either increased visual acuity or pain relief.

Accommodative Vergences in Exotropia, by P. BZIK, MD:

Claims have been made in the literature that the prism cover test at distance and near fixation is not sufficient to classify exotropias. So-called "dynamic factors" like accommodation, persistent fusional impulses, and excessive near convergence may obscure the "true" measurements.

Accommodative influence is commonly assessed by the AC/A ratio, which gives a numerical account of accommodative vergences. Our study showed that the clinical determination of the AC/A ratio by the gradient method reveals large individual differences in exotropes and therefore this ratio is not a helpful tool. This result was suspicious since usually (in normals and exotropes) the AC/A ratio has been established to be a constant value.

NEW RETINA FELLOW AT UW

Dr. Robert Blau will spend one year as a retinal fellow at the University of Wisconsin. Dr. Blau received his MD degree from Wayne University in Detroit, Mich. He served his internship and ophthalmology residency at Mt. Sinai Hospital in Detroit.

NEW FACULTY MEMBER AT UW

Dr. James Harris has joined the staff at the University of Wisconsin Department of Ophthalmology. Dr. Harris took his residency at the University of California in San Francisco. For the past year he has been doing work in diabetic retinopathy and retinal detachment surgery on a National Institutes of Health fellowship at the University of Wisconsin. He will continue his work in diabetic retinopathy and retinal detachment surgery. □

OBITUARIES

Clemens R. Kwapy, MD, 64, Wauwatosa, died June 16, 1972 in Milwaukee.

Born Nov. 23, 1907 in Milwaukee, Doctor Kwapy graduated from Marquette University School of Medicine in 1934 and served his internship and residency at Milwaukee County General Hospital. He practiced in Oconto for ten years and completed a residency in otolaryngology at Milwaukee County General Hospital. He also spent two years at University of Southern California in his specialty of ENT, and was board certified in otolaryngology. Doctor Kwapy was on the medical staff of St. Francis and St. Joseph's hospitals. He was a member of the American Academy of Facial, Plastic and Reconstructive Surgery, and a fellow of the American Academy of Otolaryngology and Ophthalmology.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Sylvia; two sons, Robert, Colorado Springs, Colo., and William, St. Louis, Mo.; three daughters, Mrs. Robert Lipscomb, Menomonee Falls, Mrs. Milton Bates, Berkeley, Calif., and Mrs. Stanley Green, Santa Monica, Calif.

Thomas B. McNamara, MD, 52, Stone Lake, died June 20, 1972 in Stone Lake.

Born on Oct. 21, 1919 in Dubuque, Ia., he graduated from Loyola University School of Medicine, Chicago, in 1944 and served his internship and residencies at Cook County General Hospital, Chicago. Doctor McNamara also was on the faculty of the University of Illinois. He served in the United States Navy, then established an ophthalmology practice in La Crosse in 1950; he retired in 1971. While in practice, he was on the medical staff of St. Francis Hospital.

He was a member of Barron–Washburn–Sawyer–Burnett County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Sarah, and two sons.

John L. Parks, MD, 64, vice-president for medical affairs at George Washington University, died July 5, 1972 in Annapolis, Md.

Born in 1908, Doctor Parks graduated from the University of Wisconsin Medical School in 1934. He began at George Washington University in 1938 specializing in obstetrics and gynecology and later became dean of the Medical School. He was president of the Association of American Medical Colleges.

Surviving are his widow, Mary Dean Scott, and a son, Dr. John Parks.

Eugene F. Traut, MD, 78, Oak Park, Ill., died July 15, 1972 in Oak Park, Ill.

Born in 1894 in Fond du Lac, Doctor Traut graduated from Rush Medical College, Chicago, and the University of Vienna, Austria. He served on the medical staff of Cook County, West Suburban, and Presbyterian St. Luke's hospitals, for over 50 years. He was the director of the arthritis clinic of Cook County Hospital, professor emeritus of medicine at University of Illinois, Rush, and Presbyterian St. Luke's medical schools.

Surviving are his widow, Wilma; two sons, Richard and David; and five daughters, Mrs. Edward Lyon, Mrs. Robert Hummel, Mrs. David McConnell, Mrs. Eugene Sullivan and Miss Martha Traut.

Chester C. Schneider, MD, 78, prominent Milwaukee surgeon, died July 16, 1972 in Whitefish Bay.

Born on Feb. 11, 1894 in Milwaukee, he graduated from Harvard Medical School in 1918 and served his internship and residency at Boston Lying-In Hospital and Massachusetts General Hospital, respectively. He was chief of staff and head of the Department of Surgery and Orthopedic Surgery at Deaconess Hospital from 1928–1962 and president of the medical staff from 1928–1930 and 1945–1946. Doctor Schneider also served as both chief of staff and head of the Department of Surgery and Orthopedic Surgery at Milwaukee County General Hospital from 1920–1950. In 1962 he retired from his surgery practice but remained on the staff of Deaconess Hospital as a consultant.

Doctor Schneider served as a consultant for the Selective Service Board during World War II and received a Congressional Selective Service Medal and a Certificate of Meritorious Service from the state. He was president of the Milwaukee Orthopaedic Society and the Wisconsin Orthopaedic Society, a lecturer of the American Academy of Orthopaedic Surgeons and diplomate of the American Board of Orthopaedic Surgery.

In 1968, he became a member of the "50 Year Club" of the State Medical Society of Wisconsin.

He also was a member of The Medical Society of Milwaukee County and American Medical Association.

Surviving are two sons, Fredric G. and Chester C., Jr., Bayside; and a stepson, Byron R. Speich, Whitefish Bay.

Donald C. Wilkinson, MD, 67, Oconomowoc, died July 19, 1972 in Oconomowoc.

Born on Nov. 28, 1904 in Oconomowoc, Doctor Wilkinson graduated from the Marquette University School of Medicine in 1928 and served his internship at Milwaukee County General Hospital. He had practiced for 44 years and was one of the original members of the Wilkinson Clinic, Oconomowoc, but terminated that association in 1962. Doctor Wilkinson served in the United States Navy during World War II and saw action in the South Pacific.

He was a member of the Waukesha County Medical Society, State Medical Society of Wisconsin, and American Medical Association. He also held a Life Membership in the State Historical Society of Wisconsin.

Surviving is his widow, Ruth.

Benjamin J. Baumle, MD, 72, Milwaukee, died July 20, 1972 in Milwaukee.

Born on July 9, 1900 in Milwaukee, he graduated from Marquette University School of Medicine in 1927 and served his internship and residency at Deaconess Hospital, Milwaukee. Doctor Baumle

served in the United States Army during World War I.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is a son, Dan R. Baumle, Glencoe, Ill.

Albert L. Babbitz, MD, former Milwaukee physician, died Aug. 6, 1972 in Hallendale, Fla.

Born on May 7, 1905 in Milwaukee, Doctor Babbitz graduated from Marquette University School of Medicine in 1931, served his internship at St. Francis Hospital, La Crosse, and completed his residency at the Milwaukee Children's Hospital. He served in the United States Army during World War II.

Doctor Babbitz was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Jean; a son, Marshall, Milwaukee; and a brother, Dr. Sidney G. Babbitz, Milwaukee. □

Wisconsin Students: Short of Cash?

The State Medical Society's Charitable, Educational and Scientific Foundation (CESF) has money available for long term, low interest loans which are interest-free until after medical school is completed. The loans are designed to "fill the gap" for students whose own resources aren't quite enough.

CESF funds are limited, so the loans can only be given to Wisconsin residents enrolled in Wisconsin medical schools—The University of Wisconsin Medical School in Madison and The Medical College of Wisconsin in Milwaukee. Deans of the medical schools must approve the applications before loans can be granted.

CESF loans are generally under $1,000 a year for a total of three years. Application forms and complete information are available at the CESF office, 330 East Lakeside Street, Madison.

Funds for these loans have been given to the Foundation to administer according to the wishes of the donors. Several of the loan programs have been set up by county medical societies for students from within that county. Physicians individually have established loan programs and others have contributed significantly to the general student loan program. Industry, too, has contributed substantially.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

Phone 567–5535
MILWAUKEE OFFICE—367–3172

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MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1972 WISCONSIN

Oct. 6: Fall Seminars of the Wisconsin Academy of Family Physicians, Sheraton Hotel, Madison, Wis. Info: Jack Strong, MD, Program Chairman, Wisconsin Academy of Family Physicians, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

Oct. 6–7: Wisconsin Society of Obstetrics and Gynecology, Pioneer Inn, Oshkosh.

Oct. 7: Eighteenth Annual Fall Cancer Conference (scrimmage). University of Wisconsin Center for Health Sciences, Room 227 Service Memorial Institute auditorium. Info: Hugh L. Davis, Jr., MD, 708-C University Hospitals, 1300 University Ave., Madison, Wis. 53706.

Oct. 7–8: Annual symposium, *Curriculum Change: Fad or Necessity?*, Medical College of Wisconsin, Ramada Inn, Waukesha.

Oct. 11: Family Practice Conference, Neenah (see details elsewhere in box).

Oct. 12: Family Practice Conference, Wausau (see details elsewhere in box).

Oct. 18: Family Practice Conference, Eau Claire (see details elsewhere in box).

Oct. 21: Immunology Symposium sponsored by Marshfield Clinic Foundation, in Marshfield.

Oct. 25: Seventh Annual Fall Cardiovascular Symposium, sponsored by the Adolf Gundersen Medical Foundation and Wisconsin Heart Association, at University of Wisconsin—La Crosse. Subject: *Congestive Heart Failure.* INFO: A. Erik Gundersen, MD, La Crosse, WI 54601.

Nov. 1: Family Practice Conference, Neenah (see details elsewhere in box).

Nov. 2: Family Practice Conference, Wausau (see details elsewhere in box).

Nov. 8: Family Practice Conference, Eau Claire (see details elsewhere in box).

Nov. 10–11: Wisconsin Neurological Society, Wisconsin Dells.

Nov. 11: Pediatric Symposium sponsored by Marshfield Clinic Foundation, in Marshfield.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

Nov. 15: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Dec. 14: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

1972 NEIGHBORING STATES

Oct. 11: *Recent Progress in the Management of the Complications of Streptococcal Infection,* sponsored by Committee on Continuing Medical Education of the Division of the Biological Sciences and The Pritzker School of Medicine. Info: Frontiers of Medicine, Rm 404, Culver Hall, The University of Chicago, Chicago, Ill. 60637 or tel: 312/947–5271.

Oct. 12–14: Recent Advances in Infectious Diseases, American College of Physicians, Mayo Memorial Auditorium, University of Minnesota, Health Sciences Center, Minneapolis, Minn. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Oct. 14–20: Annual Otolaryngologic Assembly of 1972, Eye and Ear Infirmary of University of Illinois Hospital, Chicago, Ill. Info: Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

Oct. 28: Illinois Regional Meeting, American College of Physicians, Drake Hotel, Chicago, Ill. Info: Robert M. Kark, MD, 1753 W. Congress Pkwy, Chicago, Ill. 60612.

Nov. 10: 1972 Workshop of the Institute of Medicine, Ambassador West Hotel, Chicago.

Nov. 8–10: Internal Medicine Grand Rounds, American College of Physicians, Mayo Clinic, Rochester, Minn. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Nov. 13–18: Course in Laryngology and Bronchoesophagology, Department of Otolaryngology of Abraham Lincoln School of Medicine and University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill. Info: Dept of Oto., U of Ill. Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 24–25: Conference on Radiology in Otolaryngology and Ophthalmology, Chicago, Ill. Info: Galdino E. Valvassori, MD, Radiology Dept., Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 25: Minnesota Regional Meeting, American College of Physicians, Radisson Hotel, Minneapolis, Minn. Info: Howard L. Horns, MD, 100 Melbourne Ave. SE, Minneapolis, Minn. 55414.

1972 AMA

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Oct. 2–4: *Developmental Biology and Perinatal Medicine,* sponsored by The American College of Physicians. McGill University, Montreal, Que., Can. Info: Edward C. Rosenow, Jr., MD, Exec. V-P, ACP, 4200 Pine St., Philadelphia, Pa. 19104.

Dec. 2–7: Thirty-First Annual Meeting of the American Academy of Dermatology, Americana Hotel, Bal Harbour, Fla. Info: Frederick A. J. Kingery, MD, 2250 Northwest Flanders St., Portland, Ore. 97210.

1973 WISCONSIN

Jan. 17: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Feb. 15: State Medical Society In-Depth Teaching Program, Madison General Hospital, Madison.

Apr. 11: Family Practice Conference, Neenah (see details elsewhere in box).

Apr. 12: Family Practice Conference, Wausau (see details elsewhere in box).

Apr. 18: Family Practice Conference, Eau Claire (see details elsewhere in box).

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May 9: Family Practice Conference, Neenah (see details elsewhere in box).

May 10: Family Practice Conference, Wausau (see details elsewhere in box).

May 16: Family Practice Conference, Eau Claire (see details elsewhere in box).

1973 NEIGHBORING STATES

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Feb. 7–9: Twenty-Fifth Annual Meeting American Academy of Occupational Medicine, Royal Orleans Hotel, New Orleans, La. Info: James M. MacMillan, MD, Medical Director, Reynolds Metals Co., 6601 W. Broad St., Richmond, Va. 23218.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

MEDICAL MEETINGS . . .

18th Annual Fall Cancer Conference will be held at the University of Wisconsin Center for Health Sciences Saturday morning, October 7.

The event, also known as "the Fall Cancer Scrimmage," is open to all practicing physicians and will feature five presentations on cancer detection, treatment, and management by experts at the University. Subjects include endoscopy in GI cancer, cancer chemotherapy, breast cancer, tumor associated antigens, and cancer in children.

The conference will be held in Room 227 Service Memorial Institute auditorium in the UW Medical School. Lunch will be served at University Hospitals, followed by an opportunity to attend the Wisconsin–Northwestern football game in the afternoon.

For further information contact Dr. Hugh L. Davis, Jr., 708-C University Hospitals, 1300 University Ave., Madison, Wis. 53706.

Curriculum Change: Fad or Necessity? The Medical College of Wisconsin's annual symposium on issues confronting medical educators will be held October 7–8 at the Ramada Inn in Waukesha.

A panel discussion to air ideas of guest speakers and those of faculty is scheduled. A debate on curriculum change will be led by Harold M. Swartz, MD, PhD, chairman of MCW's curriculum committee and counseled by leaders in medical education and government.

Other participants will be: L. Thompson Bowles, MD, PhD, director, Division of Curriculum and Instruction, Association of American Medical Colleges; Kenneth Endicott, MD, director, Bureau of Health, Education and Manpower Training, National Institutes of Health; James C. Strickler, MD, associate dean, Dartmouth Medical School; and Daniel Tosteson, PhD, chairman, Department of Physiology, Duke University School of Medicine.

New ideas and status reports on current and planned changes at other medical schools are part of the 1972 symposium.

A special feature of this year's symposium is the implementation of programmed instruction and the use of audio-visual aids as teaching tools for a compacted curriculum. Computer assisted instruction will be demonstrated throughout the meetings using a telephone line and terminal hook-up to Ohio State University's School of Medicine. Instructors will be Clement Benjamin, assistant chief, National Medical Audio-Visual Center, Atlanta, Ga., and Paul Y. Ertel, MD, project supervisor, Computer Assisted Instruction Study, Ohio State Regional Medical Program.

Concluding the symposium will be a Saturday evening social time with an informal buffet supper.

Interstate Scientific Assembly. The Annual Scientific Assembly of the Interstate Postgraduate Medical Association will be held in Washington, D. C., November 13–16, at the Washington–Hilton Hotel.

The Assembly will feature "live" television programs relayed direct to the meeting from George Washington University. Informal group conferences have been arranged, with light refreshments available at noon recess periods.

Subjects to be covered include: office ophthalmology, treatment of otitis, the surgeon and pancreatic disease, first year of life in newborn patient, diabetes, abdominal pain, painful foot, immunizations, office laboratory aids, neonatal jaundice, dermatology clinic, urinary infections in children, bladder infections in women, urinary problems of the elderly, anatomy of foot infections, venereal disease, thyroid disorders, cholesterol problems, professional corporations, common neurologic disorders, cardiac evaluation, hypertension, anemias, orthopedic problems in the office, hepatitis, pulmonary ventilation techniques, drug interaction, potential suicide patient, minimal brain dysfunction, genetic counseling, uncooperative mother, and asthma.

Among the outstanding guest speakers will be Walter F. Ballinger, MD of Washington University, St. Louis, Mo.; Rubin Flocks, MD of the University of Iowa, Iowa City; C. Barber Mueller, MD of McMaster University, Hamilton, Ontario, Canada; Ray W. Gifford, MD of the Cleveland Clinic, Ohio; Douglas Cameron, MD of McGill University, Montreal, Quebec, Canada; Robert H. McDonald, MD of the University of Pittsburgh, Pa.; and Edward F. Rabe, MD of Tufts University, Boston, Mass.

Faculty members from Washington, D.C.'s universities—Howard, George Washington, and Georgetown—and the Veterans Administration Hospital have major teaching assignments on the program.

The annual banquet speaker, on November 15, will be Story Musgrave, MD, a physician astronaut with NASA in Houston, Tex. His subject: *United States Spaceflight Objectives, 1972–2000.*

Special social events for the ladies, with an unusual hostess group working with Congressional wives, will provide something different and not open to the general tourist public.

A special postconvention cardiac evaluation conference will be conducted at Georgetown Auditorium from 8:00 until 10:00 p.m. Thursday, November 16, to the first 125 MDs registering. The program will consist of patient cases, use of audiphones, palpators, and group discussion. It will be presented by W. Proctor Harvey, MD of Georgetown University and immediate past president of the American Heart Association and Associates in Cardiology.

The Assembly program is acceptable for 23 *prescribed* and 2 *elective* hours by the American Academy of Family Physicians. Also accredited by the AMA Council on Medical Education and is acceptable for credit toward the Physician's Recognition Award of the AMA.

Registration fee is $25 if received in Madison by November 10. It will be $35 at the meeting. For registration form write: Interstate Postgraduate Medical Association, P. O. Box 5445, Madison, Wis. 53705; or tel. 608/263–2857.

General Practice Review: Colorado. Three sessions of General Practice Review in 1973: Jan. 22–27 in Denver, Mar. 5–10 in Denver, and June 11–16 in Estes Park. Presented by the University of Colorado School of Medicine, Office of Postgraduate Medical Education.

As in previous conferences, broad reviews and discussions of new developments at the postgraduate level will be featured in the following major fields of the general practice of medicine: MONDAY—*Medicine;* TUESDAY—*Pediatrics;* WEDNESDAY—*Dermatology;* THURSDAY—*Surgery and Trauma;* FRIDAY—*Obstetrics and Gynecology;* and SATURDAY—*Psychiatry.* (Psychiatry sessions may be moved to Monday and Tuesday evenings, thereby eliminating the Saturday program.)

The General Practice Review has employed the same general schedule and format for nineteen years. The course is not offered as a specific preparation for the American Board of Family Practice examinations; however, many physicians have found it useful for this purpose. A panel of physicians who have recently passed the Board examination will be presented and panelists will discuss their individual methods of preparing for the examination.

Tuition: $125 including a non-refundable registration fee of $10. Further info: Office of PG Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

7th Annual Cardiovascular Symposium entitled, "Congestive Heart Failure," to be held at the University of Wisconsin at La Crosse, Wednesday, October 25, sponsored by The Adolf Gundersen Medical Foundation and the Wisconsin Heart Association.

As in previous years this will be a one-day program with talks in the morning beginning at 9 a.m. by each of five prominent speakers to be followed in the afternoon by a panel discussion including the treatment of classic cases of congestive heart failure and the discussion of questions and answers from the audience.

Pediatric Symposium. The Marshfield Clinic Foundation in Marshfield is sponsoring a Pediatric Symposium November 11. Guest speaker will be Dr. Heinz F. Eichenwald, professor and chairman of the Department of Pediatrics, University of Texas, Southwestern Medical School, Dallas, Tex.

Immunology Symposium. Guest speakers for the Immunology Symposium on October 21 at the Marshfield Clinic Foundation in Marshfield will be: Gerald J. Gleick, MD, Department of Allergy and Immunology, The Mayo Clinic, Rochester, Minn.; S. G. O. Johansson, MD, University of Uppsala, Sweden; and Roy Patterson, MD, Northwestern University, Chicago, Ill.

1972–1973 In-Depth Teaching Programs

The forthcoming series of In-Depth Teaching Programs

THE EFFECTS OF MULTIPLE INJURIES

are provided by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, in cooperation with the University of Wisconsin Medical School, St. Marys Hospital Medical Center, and Madison General Hospital.

Objectives of this year's lecture series is to explore in depth the systemic effects of multiple and massive injuries. Course is designed for physicians maintaining primary care responsibility for patients.

ST MARYS HOSPITAL

Wednesday, Nov. 15, 1972
Thursday, Dec. 14, 1972
Wednesday, Jan. 17, 1973

MADISON GENERAL HOSPITAL

Thursday, Feb. 15, 1973
Registration at 9:30 a.m.

Morning Workshop Topics

*Respiratory Emergencies
*Dr. Blue, Blue-cart, Code 99, or whatever you call it
*Clinical Cardiology
*Rheumatology
*Renal Disease
*Quality of Care—Appraisal Workshop
*Proctological Problems
*Pathology for the Practitioner
*Urological Problems

Afternoon Lectures

Nov. 15: *Hemodynamics and Nutrition,* Joseph A. Moylan, MD, Asst Prof of Surgery, UW Medical School; *The Internist's Concerns,* Marvin L. Birnbaum, MD, Asst Prof of Medicine and Physiology, UW MS

Dec. 14: *The Emergency Room Physician's Concerns,* Joseph A. Moylan, MD; *The Cardiologist's Concerns,* Neville Bittar, MD, Assoc Prof of Medicine, UW MS

Jan. 17: *The Anesthesiologist's Concerns* S. Craighead Alexander, MD, Prof and Chrm, Dept of Anesthesiology, UW MS; *The Obstetrician's Concerns,* David A. Horwitz, MD, Asst Prof of GYN OB, UW MS

Feb. 15: *The Psychiatrist's Concerns for the Patient and Family,* John H. Greist, MD, Prof of Psychiatry, UW MS; *The Physiatrist's Concerns,* speaker to be announced

Fee for all four programs: $30; each program less than four: $8. Checks payable to: CES Foundation.

Advance registration should be made with David C. Reynolds, Director of Scientific Services, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Special Family Practice Conferences

SCHEDULED IN 1972–1973 AT

Neenah • Wausau • Eau Claire

The University of Wisconsin Center for Health Sciences and the Department of Postgraduate Medical Education of UW Extension announce a series of one-day "In Depth" instructional meetings for Family Physicians in Neenah, Wausau, and Eau Claire in October–November 1972 and April–May 1973.

Each day will cover two basic areas of medical practice, with instruction of a "workshop" nature in the morning and a two-hour lecture program following lunch. Morning instruction will be provided by local specialists, and UW faculty members will be used as resource personnel.

A complete series of four conferences will provide 16 hours of *prescribed* AAFP credit. Cost is $10 per individual meeting, or $35 for the series.

Cosponsors are the State Medical Society's Charitable, Educational and Scientific Foundation and the Wisconsin Academy of Family Physicians.

NEENAH Conferences—Theda Clark Memorial Hospital

Oct. 11 (Wed.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 1 (Wed.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 11 (Wed.): Cardiology and Neurosurgery
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *Manucher Javid, MD,* Professor of Surgery

May 9 (Wed.): Nephrology and Urology
UW FACULTY: *Frank D. Gutmann, MD,* Assistant Professor of Medicine; *G. H. Malek, MD,* Assistant Professor of Surgery

WAUSAU Conferences—Wausau Hospital North

Oct. 12 (Thur.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 2 (Thur.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 12 (Thur.): Cardiology and Neurosurgery
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *Manucher Javid, MD,* Professor of Surgery

May 10 (Thur.): Ophthalmology and Otolaryngology
UW FACULTY: *George Bresnick, MD,* Assistant Professor of Ophthalmology; *James H. Brandenburg, MD,* Professor of Surgery (ENT)

EAU CLAIRE Conferences—Sacred Heart Hospital (October and November); Luther Hospital (April and May)

Oct. 18 (Wed.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 8 (Wed.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 18 (Wed.): Cardiology and Pediatrics
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *William E. Segar, MD,* Professor of Pediatrics

May 16 (Wed.): Dermatology and Otolaryngology
UW FACULTY: *Derek J. Cripps, MD,* Associate Professor of Dermatology; *James H. Brandenburg, MD,* Professor of Surgery (ENT)

Those wishing to register mail check (payable to CES Foundation) of $35 for series or $10 per individual conference to Roy T. Ragatz, Department of Postgraduate Medical Education, 610 Walnut Street, Madison, Wis. 53706. CLEARLY INDICATE WHAT SERIES OR INDIVIDUAL CONFERENCE YOUR CHECK COVERS.

CONTRIBUTIONS—CES FOUNDATION
July 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1972:

Nonrestricted

State Medical Society Members	Voluntary contributions of 23 MDs
Nelson Muffler Corporation	Memorial: E. E. Bryant
Mrs. Mavis Minor, Mrs. Frances Ryan, Mrs. Myrna Wichmann, Mr. Paul Wichmann, Wisconsin Physicians Service	Memorial: Mrs. Lovina Mather
Mr. & Mrs. Earl R. Thayer	Memorial: Mrs. Stephen Ambrose
Mrs. Robert Burns	Memorial: Mrs. Frank Smith
Bill & Mary Angell	Memorial: Mrs. Clarence Nordness
Dr. & Mrs. E. D. Sorenson	Memorial: Francis L. O'Keefe, MD
Fond du Lac County Medical Society	Memorial: Karl Borsack, MD
State Medical Society	Memorials: C. R. Kwapy, MD, J. E. Gruender, MD, T. B. McNamara, MD

Student Loans

State Medical Society Members	Voluntary contributions of 2 MDs

Charitable Disabled Physicians

State Medical Society Members	Voluntary contribution of 1 MD

Other than CESF Projects

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MEDICAL MEETINGS . . .

1972–73 Frontiers of Medicine Series. Nine monthly programs will be given for physicians attending the 1972–73 Frontiers of Medicine Series at The University of Chicago. The eighth annual series, held on Wednesday afternoons, starts September 13.

Here is the 1972–73 schedule:

September 13: *Male and Female Infertility*
October 11: *Recent Progress in the Management of the Complications of Streptococcal Infection*
November 8: *Virology in Medicine*
December 13: *Mind-Body Interaction*
January 10: *Advances in Coronary Heart Disease*
February 7: *Modern Clinical Approaches to Gastrointestinal Bleeding*
March 7: *Nutrition in Prophylaxis and Therapy*
April 11: *Advances in Neurological Diagnosis and Treatment*
May 9: *The Acutely Injured Patient*

The fee for the series is $100, or $15 for a single session. The lectures will be presented in Lecture Room P-117 (the Frank Billings Auditorium) of the University's Hospital and Clinics, 950 East 59th Street, Chicago.

The program is acceptable for 27¼ *elective* hours by the American Academy of Family Physicians and for 27¼ *credit* hours for the Physician's Recognition Award of the American Medical Association.

Further information may be obtained from Frontiers of Medicine, Room 404, Culver Hall, The University of Chicago, Chicago, Ill. 60637, or by telephoning (312) 947–5271. Advance registration is requested. □

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

Meeting Wisconsin's Future Physician Needs

PRESIDENT'S PAGE

THE SUBJECT OF PHYSICIAN MANPOWER to meet the needs of Wisconsin's population growth has commanded the attention of the State Medical Society and various citizen research study groups. It is estimated that Wisconsin will have a population of 5,220,000 by 1985. That is just 13 short years from now.

On March 6, 1967, Governor Warren P. Knowles appointed a very distinguished committee known as the Governor's Task Force on Medical Education. This Task Force of 20 informed citizens and physicians was headed by Mr. Donald C. Slichter of Milwaukee. It was directed to make an in-depth study of Wisconsin's current medical education facilities, the state's current medical manpower, and projected future needs. The expansion of present medical school facilities together with development of new teaching centers was also to be studied.

The Governor's Task Force on Medical Education went to work and did a remarkable job of documenting Wisconsin's current and future medical education and physician manpower needs.

Very briefly, these were the Task Force's findings:

- Wisconsin's resources for health care in terms of physician manpower are below the national midwest average. Nationwide there are 143 physicians per 100,000 population; Illinois, 137; Minnesota, 148; Wisconsin, 119.
- Wisconsin has experienced an annual out migration of 19 newly trained physicians over the past 11 years.
- The drop-out rate of students at our two medical schools in this state is higher than the national average.
- Postgraduate educational opportunities in this state are below the national average and undoubtedly contribute to Wisconsin's net annual loss of newly trained physicians.
- To provide a level of physician manpower close to the anticipated average by 1985, this state must expand its program for training new physicians from 211 first year places now to 420 first year places by 1975–77, and expand and strengthen the postgraduate education programs to at least balance the number of migrating physicians.

These were some of the pertinent findings of the Governor's Task Force in 1967. The problems confronting Wisconsin five years ago are still with us as the time clock keeps ticking on. Plans for the Medical Center of Southeastern Wisconsin received a jolt last month with the announcement that the Medical College of Wisconsin had its $15,000,000 funding application rejected. One week later the school announced that its private fund drive had been halted.

This school's leadership has displayed an amazing variety of bungling since the Jesuit fathers surrendered their control in September 1967. This school has received state funding assistance during this five-year period. One-third of the directors of the school are public representatives on the board. These latest giant steps backward have put the entire Medical Center of Southeastern Wisconsin, including the Froedtert Memorial Lutheran Hospital, the new Milwaukee Blood Center, and the new Curative Workshop, in limbo. The need for new leadership at this fine school is apparent. Wisconsin cannot afford to have the carefully developed plan for a great medical center put in jeopardy. It might well have a stunning adverse effect upon the prophetic recommendations of a splendid Task Force of five years ago.

Robert F. Purtell, M.D.

ROBERT F. PURTELL, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

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MEDICAL JOURNAL

Transition—second of a series

LAST MONTH CONSIDERATION was given to the effect upon our practice of medicine of many real changes that are occurring in our world, both technically and socially. One further result of all this is that there seems to be an accelerating increase in the choices available to us. There are more places we can go, there are more ways to get there, and a widely expanded number of things to do once we get there. In medicine there is an increasing range of choices for both patient and doctor. At the ground level, of course, we have the probes into genetic control, researches into the mysteries of several major diseases, vast new ranges of treatment possibilities and complex hospital and outpatient networks for patient care, most of which require a map to find one's way in and to the proper spot. With all these basically sound advances comes nonetheless the inevitable problems never dreamed of by our grandfathers, the kindly practitioners of the past. These men worked for the most part out of a single office, and a hospital was for them just a place for nursing and sometimes surgical care. They were not faced with the impressive array of specialties we see today, or of the complicated choice of which specialty to use for a given person, or whether to enter into the folds of some specialty himself, nor the even more complex decisions as to which individual, among several in any given specialty should be encountered. He, this solo practitioner of old, did not have to puzzle whether to send his patients with chronic back pain, with or without slipped discs, to an orthopedic surgeon or to a neurosurgeon. He did not have to decide whether to hospitalize his mildly depressed patients in a general hospital, in a psychiatric hospital, or whether to send them to a "dynamically oriented" psychiatrist (which means to some a psychiatrist who will do something besides talk to his patients; e.g., drugs, shock, and the like) or whether to send the depressed patient to a psychoanalyst who might uncover unpleasant webs of thinking and perhaps even reorganize the patient's manner of going about his life. And, of course, this grandfather of ours did not have to think and know which psychiatrist fitted which patient or how to get into his crowded schedule. And this is just the beginning. All of you know and daily face the ever increasing range of choices available in medicine.

But this is no simple choice in a candy store between chocolate and ginger, for the decisions we now make have profound effects upon the lives of people. Add to this the complexities of government control systems, which simply must get into the details of specialties to function. We can question whether they should—and that is another subject—but so long as the complexities exist, any plan to supply complex medical service must include choice and range of choice. It is becoming increasingly difficult to get reliable information, not due to stealth but due to complexity, about such problems across the United States. Should only board certified surgeons be paid by the Blues or by state insurance commissions, or even more complicated, should a psychiatrist with all the certificates be paid for treating a patient whom he would class as an alcoholic when that patient's insurance will pay only those doctors and social workers who participate in a formal "alcoholic rehabilitation program." Well, of course, this one is easy, for it is only necessary to set up some formal structure, pretend that alcohol is a disease rather than a chemical used by some sorts of distressed people and continue to do what you have been doing for thirty years anyway. But will the next subtlety be as easy, and what does the general practitioner do as the various parts of disease become flavored into more and more precise and specified areas. What if he does not agree that epilepsy should be treated only by skilled workers in an established clinic, or—well the list is endless. As far back as 1945 I recall with chills the "sore throat" ward that was mine to attend as a first lieutenant, MC in the Army. If pus collected on the tonsils or fever went above a certain point, the soldier had to be transferred, by order, to another ward. So much for my comprehensive Army experience. The point becomes one of the serious nature of widening choices, the increasing difficulty in knowing just what all our choices are, let alone knowing the implications of that choice to the other humans, and facing our own doubts, even our own impotence to really know whether we have a sound basis for any given choice. As choices and varieties continue to open up, experiment we must, monitor results we must, and someplace decide how to go about the practice of medicine. And if you believe the choices are difficult for the physician, who at least has some training and experience in health matters, think for a minute how much more difficult it must be for governmentally oriented persons to decide whether to certify physicians or chiropractors, or acupuncture —and for the treatment of what diseases, or parts of diseases. Lastly, but by no means the leastly, the patient himself frequently determines his choice. I

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seriously doubt if the legal decisions or the patient's decision are as generally sound as would be a composite medical decision. But that is not always our choice to make. In my particular practice, admittedly esoteric, nearly all persons treated are self-referred, or now after twenty-five years, referred from other patients. I get less than one referral per year from other doctors. Of course this is special, and I've many medical friends whose specialty practice is nearly 100 percent physician referral. Yet the choice of routes to a doctor is becoming so complex, and to some these routes are vague enough to force a reorganization of their own value system (not always to our advantage as physicians), which may ultimately lead all of us into a frantic search for new values, new methods of determining what are suitable medical systems, and how best to get them across to the public. Pounding our fists on our own council tables may be one way, but likely not very effective. Maybe the careful study of variable, such as is being attempted in this series of editorials, is another way to begin knowing what to do about our public image. We all share this, no matter what our skills or our person bias.—RH

The Cult of Acupuncture

SINCE PRESIDENT NIXON'S return from China the ancient technique of acupuncture has become a burning issue. Because of the sensational claims made for it, the popular press and television have taken it up as though it were some new panacea for all the ills that modern medicine can't cure.

Oddly enough, responsible medical publications including *Today's Health,* an organ of the American Medical Association, are printing articles about acupuncture suggesting that it is a miraculous, ancient, over-looked procedure, the rediscovery of which we owe, with gratitude, to President Nixon. *Modern Medicine,* in its July 24, 1972 issue, reports that there is "strong interest in acupuncture by once skeptical U. S. researchers," that there are proposals for joint Chinese–American research efforts and attempts to coordinate American studies of acupuncture.

On July 15th *U. S. Medicine,* presumably with a straight face, headlined the opinion of a Phoenix, Arizona general practitioner that "Oriental Procedure Could Provide New Depth to Western Medicine." The story went on to report that Dr. William A. McGarey told his colleagues that "Western medicine tends too much to stress the scientific aspects of healing" and that "acupuncture cannot be comprehended without an understanding of the Taoistic principle of the duality of man."

As has been pointed out in numerous publications, acupuncture has been practiced in Western medicine for decades, both for anesthesia and for therapy of specific disease. It is taken much more seriously in Europe than it is in North America, and in Russia it is studied as a phase of "psycho-

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LETTERS

"The forces for good are not working as hard as the devil"

Hurray for Dr. John J. Brennan! (LETTERS: "Innocent human life must be protected," WMJ, August 1972) It is most refreshing to hear a pro-life, common-sense voice amid the din of "down with population" irrationalities and inconsistencies that are being pushed today.

Following a recent staff meeting at one of our local hospitals, during which one of our pediatricians presented a paper on the work being done by newborn intensive care units, one of my colleagues said to me, "There is an awful lot of hypocrisy in medicine today." "Just the other day, I received another request from New York for abortion referrals and, on the other hand we have this;" referring to the paper just presented.

I said, "Yes, doctor, on the one hand there is a vulture-like scramble for spare parts for those of us who were lucky enough to have been allowed to be born and have been allowed to live so far and, on the other, we have the fiendish demands to annihilate the fresh, young unborn life that is to come.

We say that the death penalty for proven murderers is cruel and inhuman punishment and many of us don't blink an eye when those who are innocent, even of their own origin, are being slaughtered.

What an unholy world this is getting to be and in what twisted and devious paths we are traveling! How has all this come about? Probably like the good old Irish lady, who always found something good to say about everyone who was being flayed by her gossipy friends answered one gossiper, who angrily said, "You would even find something good to say about the devil!" "Aye", said our friend, "He's an industrious fellow!" That's it! The forces for good are not working as hard as the devil. Shame on us!

ANN CINELIS, MD
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Sheboygan, Wis. 53081 □

neurological" research. European physicians who practice acupuncture have joined together into the International Society of Acupuncture, with headquarters in Paris.

The sudden, widespread interest in acupuncture in the United States has all the characteristics of a fad and it would probably be dismissed as such if it weren't for the fact that respectable medical scientists are taking the matter seriously. The State of California has authorized research into the technique and doctors all over the country are looking at it as a possible addition to their therapeutic armamentarium. In an effort to explain that it does work, sometimes, investigators are trying to relate acupuncture anesthesia to the "Melzack–Wall spinal gate control theory," and some otherwise sober physicians are trying it out even though they don't know why or what. The assumption seems to be that "there must be something to it" because all those Chinese can't be wrong. Besides, you can't deny the evidence of your own eyes when you see a surgeon remove a lung or a uterus while the patient meditates on the thoughts of Chairman Mao gleaned from the Chairman's little red book clutched in the patient's hand.

Maybe the medical profession in the United States has been rendered so sensitive to criticism by the repeated attacks of non-scientific weirdos and the high priests of folk medicine that we are bending over backward to be open minded about something that should be branded as pretentious at the very start. Any medical technique based on a Taoist metaphysical theory declares itself immediately outside the province of serious medical science. Research into the control of pain is a legitimate scientific pursuit but that research, when it is productive of results, is based on recognized and accepted scientific method, and is explained in terms of verifiable facts. It never depends on the researcher's understanding of an esoteric philosophical theory.

Acupuncture anesthesia has been explained by Dr. William S. Kroger of the Institute for Comprehensive Medicine, Beverly Hills, California, in a letter to *Medical World News,* August 4, 1972. He says that it is "hypnosis in slow motion." The "ceremonial-like insertion of needles heighten suggestibility to induce a strong belief system reinforced by the antecedent variables characterizing Chinese culture. . . . Like hypnoanesthesia, acupuncture, too, depends on belief, confidence, and conviction—all processed into faith."

The same seems to be true of acupuncture used for arthritis, migraine, insomnia, hay fever, duodenal ulcers and all the other ills that conventional medical science has trouble treating, and that often respond to bizarre therapy. If successful acupuncture

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depends on the susceptibility of the patient to suggestion, a structure of belief and a reliance, perhaps, on the efficacy of the wisdom of Chairman Mao, it obviously has no place in medical practice, and it should be decisively branded as the cult practice it is. It should be categorized with chiropractic, naprapathic, copper bracelets, zone therapy, fad diets, and the other enthusiasms of the kooks.

Once medical science allows the elephant of non-scientific folk medicine to get its nose inside the door, we will have to contend with all the other "cures" that seem to work—sometime. We will have to abdicate the refinement of scientific practice, perhaps abandon the scientific method itself, and devote ourselves to the application of non-rational treatment. Instead of sending our patients to hospitals we might send them to Lourdes, where miraculous healing has taken place, or to miracle-working gurus and evangelists. We might have to revert to venesection, the application of leeches or the administration of nice bowls of chicken soup—all of which have respectable records of restoration of health.

Clear thinking medical men should recognize acupuncture for what it is: a cult technique. We must not be influenced by the present apparent rapprochement with the Peoples' Republic of China into giving up the progress Western civilization has made in scientific medicine for a metaphysical technique. Let us not confuse acupuncture with research into the mechanisms of pain and its relief. Let us not be blinded by the glitter of mysterious technique even when the crowd acclaims it as miraculous.—DAVID N. GOLDSTEIN, MD, Kenosha

A New Hazard

BECAUSE WISCONSIN has seen such an increase in the use of snowmobiles, and since our weather and terrain is likely for some time to attract these new devices, your attention is respectfully called to a review of injuries due to snowmobile use. Doctors Kritter and Carnesale and Sister Diane Prusinski, sm, have done us all a service by their detailed recording of causes and extent of injury from this new source. It recalls to old timers the flood of injuries, and papers about them, when it became possible to produce a gasoline engine small enough to drive a two-wheel bike. Improvements will be made in power, and some in safety for both motorcycle and snowmobile. The physician will need to be alert to these special hazards, especially the personal ones, only barely alluded to in this excellent article.—RH □

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MAINTAINING THE Quality of Health Care IN WISCONSIN

A discussion paper prepared at the request of the Personal Health Services Work Group of the Governor's Health Planning and Policy Task Force

AUGUST 22, 1972

BY

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Doctor Hirschboeck is a member of the Governor's Health Planning and Policy Task Force, State of Wisconsin; and Doctors Hansen and Holmes are members of the Task Force staff.

The Governor's Health Planning and Policy Task Force on Sept. 8, 1972, approved the following statement:

The Task Force approves the release for discussion of the paper, Maintaining the Quality of Health Care in Wisconsin, which proposes the designation of a publicly accountable but non-governmental entity to develop, assist, strengthen and coordinate, on a statewide basis, quality review of health care at the local level.

The work of the Task Force began in mid-1971, and public meetings were held in Milwaukee, La Crosse, Eau Claire, Green Bay, Oshkosh, Spooner, Stevens Point, Rhinelander and Madison to elicit information and opinions on issues and problems in health care in Wisconsin. After identifying problems, several work groups were formed to research the problems and propose solutions to them. Contributions from numerous organizations were sought and received during that process.

The Task Force during July—September, 1972, reviewed and amended the background papers and proposals put forth by its work groups during the first year of the 18-month life of the Task Force.

These ideas are currently being circulated as "proposals for public discussion," with final positions to be taken by the Task Force after suitable modifications in light of public response.

Comment, reaction, and suggestions for modifications of the Task Force proposal on quality maintenance and review, described in the accompanying paper, are earnestly sought from providers and consumers of health care in Wisconsin.

While the Task Force will of necessity take final positions on this and other proposals during October and November, in order to meet the Governor's deadline of Nov. 30, 1972, for submission of its report, the dialogue which has been established will go on indefinitely, via mechanisms such as the Wisconsin Health Policy and Program Council, as will cooperative efforts to strengthen the system of delivery of health services in Wisconsin.

ABSTRACT

Background

In its preliminary work the Personal Health Services Work Group identified the maintenance of a *consistent* and *uniform* high quality of care throughout Wisconsin as a goal of high priority.

During the last decade, peer review of health care charges, utilization, and quality have become increasing responsibilities for health practitioners. There has been, however, little uniformity of procedure. Professional responsibility for carrying out charge and utilization review, especially that required by expanding federally funded programs (for example, Medicare, Medicaid), have placed substantial burden on providers of care. Efficient and educationally or professionally useful review of *quality* of care remains underdeveloped.

The need to achieve consistency and uniformity in quality maintenance is recognized by all health professional groups. Health Care Review, Incorporated, sponsored by the State Medical Society, State Dental Society, and Wisconsin Hospital Association, is an example of the awareness of need for statewide support and coordination of review of health care practices, and commitment to these responsibilities.

The Task Force group which has examined the quality review issue believes that an organization (or organizations) responsible for support and coordination of local quality review should be created at the *state* level. The functions that are proposed in the discussion paper for such a body are:

1. Promote and assist development of local or regional quality review systems.
2. Develop statewide standards for practice performance and outcome, working with and calling upon resources of: (1) governmental agencies (including state research/development and evaluation agencies), (2) health profession associations and groups, (3) schools of health sciences, and (4) the Wisconsin Regional Medical Program.
3. Work with Areawide Health Planning Agencies to adapt standards to unique needs or problems of an area.
4. Provide means for *all* health professionals to participate in and contribute to the system of quality review of health care.
5. Provide opportunity for consumer representatives to participate in: (1) proposing standards and policy for quality review, (2) establishing grievance procedures, and (3) promotion of consumer understanding of standards of care.
6. Provide procedural means to adjudicate grievances or disagreements short of legal action, when these cannot be settled at the local level.
7. Certify approval of those review systems with acceptable performance. (Such a role would be analogous to a bank examiner who periodically ascertains that the system is functioning correctly.)

The functions of a state-level quality maintenance body would include development, or ratification, of guidelines and standards of care to be used by hospitals, professional societies, individual providers, government agencies and programs, third party payers, litigants, and others.

Implications

This proposal indicates that the Task Force takes the position that quality maintenance is a public as well as a professional responsibility. As statewide systems of review are developed by professional groups, the proposal asserts that such systems should be developed under guidelines which assure proper public as well as peer accountability. The flexibility and confidentiality of the quality review processes, as done by competent peers, should be maintained and strengthened. The public should understand the ways in which they may use and be protected by quality review.

Next Steps

The guidelines for a state-level quality maintenance agency will be proposed to professional organizations, groups affected by changing quality review practices (such as third party payers) and to citizen representative groups (including the Areawide Health Planning Agencies).

In particular, Health Care Review, Inc. will be asked to respond to this proposal and to address its role in meeting these objectives.

Detailed recommendations regarding the site of authority from which responsibility for quality review is delegated will be made as final Task Force action is taken on Council structure, regulation, and licensing.

Consultants

A wide variety of professional groups have been asked to define proper quality control practices. These have specifically included the Wisconsin State Medical, Osteopathic, Dental and Nursing Societies and a large variety of specialty groups.

Other consultants have included:

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DISCUSSION PAPER—PERSONAL HEALTH SERVICES WORK GROUP

August 22, 1972

Maintaining the Quality of Health Care in Wisconsin

THE QUALITY OF HEALTH CARE is dependent upon the skill, interest, and concern of the health care providers delivering services. The citizen seeking care also has important responsibilities, and quality can be promoted by knowledgeable consumers having realistic and appropriate expectations.

The citizens who worked with the Task Force in its first phase identified significant problems of quality of health care. The Personal Health Services Work Group has summarized several aspects of the problem as follows:

1. Quality of care and the quality maintenance practices are not uniform across the state.
2. Expectations and actions of both provider and user may not, in some cases, be consistent with standards of high quality.
3. Quality maintenance practices are often unrelated to ongoing educational activities, and may be a significant burden to health workers without proportionate benefits to them.

Measures of quality must apply not only to an individual or a single illness but also to the effects of care practices on the collective health or health care of community, state or nation. Assessment of quality of care is difficult but can be approached in several ways.

Quality of care received should principally be measured by the *outcome* of that care. Are people made healthier and less disabled? Outcome has been conventionally measured by mortality and morbidity (illness, disability, discomfort). Increasingly the outcome of care must be measured by positive health and by degree of recovery and rehabilitation.

Quality may also be related to measurements of the characteristics of the *process* of care—its comfort, appropriateness, efficiency, convenience, and cost—cost not only of dollars but also of other scarce resources, especially professional time. It is often these measures, rather than the ultimate outcome of care, which are most easily recognized by the consumer.

In addition to evaluation and "control" of care by consumers as they choose particular providers (competition in the market place), the control and assurance of the quality of health service, as it exists today, draws upon many governmental and nongovernmental activities.

1. Examination (established by statute) of personnel as to ability to work in the health care system, and subsequent legal privilege to practice (licensure).
2. Certification and registration of health workers by quasi-public professional groups.
3. Licensure and accreditation of health facilities.
4. Accreditation of educational institutions preparing health workers.
5. Standards and administrative rules established by state and local health departments.
6. Guidelines and standards established through professional or peer review of health care practices.
7. Hospital and medical group practice staff regulations that require medical and surgical audits and utilization review.
8. Guidelines and standards used by governmental and private third party payers.
9. Precedents established from court decisions in practice-related litigation.

These factors mutually concern government, citizens, third party payers, and providers of health care. The effectiveness of quality maintenance processes and the policy upon which they are based will depend upon a recognition of the interdependence of these elements and their inclusion in an operational system to carry out quality maintenance of health services.

The optimal attainable standards and quality maintenance methods in use at any time or place should be derived from a consensus achieved by providers of health services, who appropriately represent the health professions, representative knowledgeable consumers, and government which is accountable to society. Both providers and consumers should understand the actual capabilities of the health care system itself and the priorities and capabilities of the public in caring for their personal health. Quality should be measured against optimal standards as modified by the exigencies of a particular situation, with a clear statement made of acceptable limits. It is generally recognized that quality maintenance should be closely tied to ongoing educational activities. Interest in strengthening one's education and motivation to achieve excellence in practice are powerful aids and incentives for most health workers, and serve to promote high and consistent quality of practice.

The several means by which quality of care can be maintained and guided have received considerable Task Force attention. Issues of licensure, continuing education, and regulation of the cost of health care practices are addressed elsewhere in the Task Force proceedings.

This position paper is concerned with three issues: (1) professional and peer review; (2) knowledge, by consumers, regarding the standards of quality of health care; and (3) mechanisms for resolution of grievances related to health care.

Problems and Strengths

As health care has become increasingly complex and expensive and as the role of third party payers has grown in recent decades, the demands placed on providers for efficient and appropriate use of health facilities and services has grown accordingly.

The term "peer review" has commonly been applied to three related but distinct processes: (1) utilization review (for example, appropriateness of hospital admission, or length of stay); (2) review of charges and claims; and (3) review of the quality of care itself—professional audit. It is not surprising that the most active development of peer review processes has been in the professions which render direct charges to patients, especially dentistry and medicine. The magnitude of demands placed on utilization and charge review has, to a substantial degree, diverted attention from the review of the quality of care itself.

Organized provider groups have anticipated public expectation and governmental demands in organizing for the performance of health care review. This was most explicitly stated in the press release by Wisconsin Health Care Review, Inc. on the day of its incorporation.

> *The professionals hope that by establishing their own peer review corporations in advance of any legislation requiring them, they can avoid having burdensome structures imposed by government. The professionals feel they know their own business best and hope to be able to convince government on the basis of experience that the peer review corporations work.*[1]

Hospital utilization review committees were formed in the late 1950s and early 1960s for the purpose of "review of hospital admissions with respect to need for admission, length of stay, discharge practices, and evaluation of the services ordered and provided."[2]

Public Law 89–97, enacted by Congress in 1965 to establish Medicare and Medicaid, made utilization review of services provided to beneficiaries mandatory in participating hospitals and extended care facilities, including the requirement for review of extended-stay cases. Review of appropriateness of care was expected both from the standpoint of cost and of quality of service rendered.

The American Medical Association has held that the primary function of quality review is one of education, and its Board of Trustees has urged hospital staffs to keep the quality review function distinct from utilization control and extended-stay case review.[3] Peer review has been seen by the AMA to be an educational re-examination of a physician by his equals—practicing physicians of the same area and, preferably, of the same specialty. This view is shared by most professional groups.

There is now rather general acceptance of the concept of peer review of practice by health profession groups. Each group recognizes the importance of establishing standards for the practice of its members, and clearly prefers that review be conducted by its members. It is increasingly common for allied health groups to stress the responsibility for review of *health* care (as contrasted with specific *nursing* care, *medical* care, *physical therapy* care, and the like) as a multiprofessional responsibility to which all professions have a contribution.

The involvement of providers of care in the evaluation of efficiency and quality of care practices has had the advantage that the practitioners who were in the best position to make these judgments assumed responsibility for making them. Quality review has improved with little additional public expense. Peer review has been demonstrated to have an effect in upgrading the competence of practitioners.[4] Providers have been increasingly aware of the effect of their decisions on the system of health services as a whole.

Some criticisms have been raised against medical audits organized by county or state medical societies or by hospital medical and surgical staffs. Such systems lie almost entirely within the control of the providers and are little known or visible to the public. This invisibility results in a loss of potential educational gain to the consumer. Moreover, influence on care rests almost solely with the provider.

The absence of clear pathways to resolve grievances regarding care has been a factor in the accelerating number of malpractice suits being filed. The consumer recognizes no other recourse than the courts. Effective peer review coupled to an objective arbitration process offers an alternative to litigation.

Another disadvantage of the relatively informal peer review process as it exists is that there is great variability in the assiduousness with which providers address this responsibility in different locales. The federal requirements for Medicare and Medicaid are not stringent (although requiring a vast amount of data collection) and can be met with procedures that fulfill the letter but not the intent of quality review practices. If applied very rigorously, utilization and charge review can preempt the available professional manpower at the expense of more fundamental quality review, and may over-burden the care system itself.

One may ask a basic question. Should an industry be delegated the authority to police itself? In the field of health services there are at least two reasons to answer this affirmatively. First, the judgments involved in reviewing quality of health care demand highly developed professional competence. Secondly, there are a great many providers working primarily in small separate units, which makes outside review difficult. However, the complexity of review of care can easily divert necessary manpower from the delivery of care.

For these reasons a system of professional self-review and regulation, supported by and under the supervision of a publicly-accountable body, has considerable merit and rationale in the health industry and can be delegated only with risk of trivializing and distorting the process.

Models of Health Care Review in Wisconsin

In addition to review processes established in hospitals and practice groups, peer review has been organized on the regional and state level by medical and dental societies. The "foundation" concept, pioneered in 1954 by the San Joaquin County (California) Medical Society, has been an increasing influence. The typical foundation is a tax-exempt, non-profit corporation with its own board of directors which is separate from the parent medical society. It is legally able to deal with government agencies and insurance companies that provide financing for health services. The foundations have as their purpose the use of peer review to maintain high standards of health care while safeguarding the most efficient use of limited personnel, resources, and facilities.[5]

An innovative approach was taken in Wisconsin with the incorporation on December 29, 1971, of the Wisconsin Health Care Review, Inc. (WHCRI). This organization was formed by the State Medical Society of Wisconsin, the Wisconsin Dental Society, and the Wisconsin Hospital Association to "act as a monitor of relationships among patients, health care providers, and the groups which pay most of the bills, such as insurance companies and government agencies."[6] The WHCRI is intended to encourage the formation of local review bodies, assist in the development and adoption of standards for evaluation of care, and collect and supply information on results to local peer review groups upon which they might base effective quality reviews. Consultation services would be made available to providers, review bodies, governmental agencies, the insurance industry and consumers. The proposal for the organization stated the following goals and objectives:

> *The ultimate goal of Wisconsin Health Care Review, Inc. is to establish a system which can provide authoritative information, expert opinion, and advice to governmental agencies, intermediary insurance carriers, and the public in general regarding the quality, adequacy, and availability of and necessity for preventive, diagnostic, therapeutic and rehabilitative services rendered by all providers of health care and maintenance in Wisconsin.*[7]

The WHCRI Board of Directors initially included four physicians, two dentists, and two hospital administrators. Three consumer representatives will be named to the Board. Additional provider groups as well as third party payer will be encouraged to join WHCRI as it becomes fully operational.

The organization is designed to eventually support itself by charging fees to those who use its services. Initially it was subsidized by the three groups who participated in its organization. A developmental award of $25,000 was approved for nine months by the Wisconsin Regional Medical Program (WRMP). Dependent upon the success of the developmental award, a full three-year grant at approximately $97,000 per year may be awarded. As of August, 1972, one staff person has been appointed. He is located at the State Medical Society, 330 East Lakeside Street, Madison, Wisconsin. The State Medical Society is supplying additional part-time assistance of other professional-level employees until additional employees can be hired.

Several other quality of care review programs are in existence in Wisconsin. The Marshfield Clinic has a health service delivery research and evaluation program. It has the potential to deal with office practice as well as hospital records. The existing data processing capability of the Marshfield Clinic is being utilized. Funds have been provided by the Wisconsin Regional Medical Program and the Marshfield Clinic Foundation.

The Section of Statistical Services in the State Division of Health has had considerable experience in the collection and analysis of health statistics and facility data. It has well established statewide relationships with health facilities, experience in cooperating with federal data requirements, and access to the data processing and computer skills required for large data systems.

The three Area Health Officers of the Division of Health have special responsibility to assist providers in complying with the review requirements of the Medicare and Medicaid Programs.

The Individual Physician Profile Program conducted by the University of Wisconsin's Department of Postgraduate Medical Education affords a mechanism to review the practice profile and promote the continuing education of individual physicians. The project has been supported by WRMP and, more recently, by the Kellogg Foundation. The latest grant, obtained with the Wisconsin Academy of Family Physicians, will assist over 400 practices. The individual practice profile method has been incorporated as an evaluation mechanism into a project of the State Division of Health, working with allied health professions.

Health Service Data—Wisconsin, a system to facilitate hospital care and utilization review, has been developed in close cooperation with the Department of Preventive Medicine at the Medical College of Wisconsin.

The State Medical Society of Wisconsin through its Committee on Peer Review (formerly known as the Committee on Utilization Review) has engaged in a variety of review efforts relating to quality, use, and cost. Many of these efforts have been conducted in cooperation with similar committees within the 54 constituent county medical societies.

A number of larger practice groups within the state are reviewed regarding quality of care and care review practices as a condition and responsibility of membership in the Association of American Medical Clinics.

Wisconsin Regional Medical Program also is currently active in the establishment of guidelines and standards for development of cardiac surgery units, radiation therapy, and renal disease. More work of this type is anticipated in the future.

The above list does not pretend to be inclusive. Numerous other organizations are active in the review of quality of health services being rendered in Wisconsin.

Consumer Understanding of Health Care Review Practice

As health care has become more and more dependent on complex organization, on multiple and confusing relationships between providers and consumers, and on dramatically expanding bodies of knowledge in the many health professions, it has been increasingly difficult for consumers to understand "quality" or the organization of care itself. Moreover, different professional groups may interpret the issues and facts of care practices differently. It is no wonder that "peer review" is inaccessible to the view of consumers and "quality" of care becomes a mystery, particularly in the difficult areas of outcome of treatment, where consumer expectations may be either too low or inappropriately high. It is clear that citizens need to have guidance in what to expect of the health care providers and the health system. A summary of effective professional and peer review and its standards, if made accessible to the view of the consumer or to his representative, could be a powerful source of consumer education. Professional and peer review is incomplete if accounting of it is not made to some publicly accountable body in terms understandable to laymen.

Grievance Procedure

The dramatic rise of medical malpractice litigation in recent years has many causes. Important among them is the absence of efficient and workable grievance procedures by which to resolve problems that arise between providers and consumers. County medical societies have traditionally afforded a mechanism for the registration and arbitration of consumer complaints. These have frequently focused on matters of fees charged. This appeal procedure has not adequately filled the educational and corrective roles of a neutral, publicly visible arbiter and register of accepted health care practices. Adequate grievance procedures must be based on standards of practice that are consistent with up-to-date professional and scientific capability, and with performance of care that is acceptable to reasonable and knowledgeable consumers and providers. The standards to be used in the resolution of grievances should be those utilized in peer review. As such, the standards must be understandable by consumers. Some review and referral procedures, outside the local area, will certainly be necessary in some cases.

The Role of State Government

The State has the authority to regulate the provision of health services through the controls inherent in its power to protect the welfare of citizens. It exercises its authority in limited fashion. The actual regulation, supervision or control of health care, except in certain instances of contagious and communicable disease, and many activities relating to environmental health such as sanitation, has been minimal, or quite indirect (as through licensure). The responsibility for quality maintenance has been implicitly delegated to practitioners via their license to practice or to professional organizations who undertake "delegated" responsibilities for assuring the quality of practice of their members. Standards which the state does adopt (as in granting reciprocity for licensure or for approving payment under public funding of care) are frequently developed by professional groups or accrediting bodies, often at the national level. As an example, the programs of the State Bureau for Handicapped Children are permitted to pay only for services of certified specialists.

At the present time, the State has not clearly identified responsibilities for setting the standards of health care, nor is there clear delegation, in the sense of the preceding paragraph, of a responsibility to develop and maintain a health care quality control system.

The characteristics of such a system and recommendation of actions to be taken in the public interest to develop such a system are presented below.

Characteristics of Acceptable Peer Review Practices

1. Peer and professional review should occur mainly at the level of practice, and close to the location of patient contact.
   (a) Participation in review should include all qualified *participants* in care: specialists, generalists, and allied health professionals; the review of practice should not be delegated to outside "experts."
   (b) "Peers" should be so defined to allow inclusion of persons having comparable contribution to care—not simply "like" examining "like."
   (c) Certain aspects of care are unique to the competence of the profession providing that care and must be reviewed within that profession. In areas of overlapping contribution the several professions involved should each contribute to the review process.
2. The care provided by all practitioners must be reviewed.
3. Comparable and consistent standards should exist throughout the state—significant local variation in quality or in review is NOT acceptable.
4. Review and maintenance of quality has a cost. Society must be willing to purchase "equal access" to quality care at a realistic cost.
5. Data upon which to make judgments is needed and must be readily available. Data collection must be ongoing, current, and appropriate to the judgments made. However, in no case can "good data" be a substitute for good care.
6. Practice and care should be susceptible to review originating in several ways.
   (a) Random sampling of visits or hospitalization;
   (b) Recognition of consistent divergences from usual standards of practice (for example, unusual frequency of use of a procedure);
   (c) Review of specific disorders (for example, examination of the care of diabetes); and
   (d) Review initiated by a complaint by another professional or patient.
7. Clearly established patterns of due process in the review mechanism and in any actions taken are essential.

8. Assistance to reviewers in clerical/technical tasks of review is necessary. If possible, some steps should be automated. The work of reviewing care should always be a very small fraction of the work of delivering care.
9. Positive reinforcements (effective educational support is particularly valuable) for participation in review are required.
10. Sanctions to affect unacceptable practice and to enforce effective review (such as limitation of hospital or practice privileges) are necessary but should be used as little as possible.
11. Means should exist to summarize standards and outcomes of the review process for public understanding so the sense of "good quality of care" can be achieved by the public.

Coordination and Support of Peer Review

The capacity to organize and maintain peer review at the local level varies widely. To succeed in achieving *consistency* of quality and quality maintenance throughout the State, both support and coordination of local peer review practices will be required.

Recommendation

A PUBLICLY CHARTERED BUT NON-GOVERNMENTAL BODY (OR BODIES) SHOULD BE CREATED TO PROVIDE SUPPORT AND SUPERVISION AT THE STATE LEVEL FOR CONTINUED DEVELOPMENT AND STRENGTHENING OF A SOUND SYSTEM OF PEER AND PROFESSIONAL QUALITY MAINTENANCE.

This body is referred to, for discussion purposes, as the *Health Service Quality Maintenance Agency (HSQMA).*

Functions of the HSQMA

The HSQMA should be charged to:

1. Promote and assist development of local or regional quality review systems;
2. Develop statewide standards for practice performance and outcome, working with and calling upon resources of: (1) governmental agencies (including state research/development and evaluation agencies), (2) health profession associations and groups, (3) schools of health sciences, and (4) the Wisconsin Regional Medical Program;
3. Work with Areawide Health Planning Agencies to adapt standards to unique needs or problems of an area;
4. Provide means for *all* health professions to participate in and contribute to the system of quality review of health care;
5. Provide opportunity for consumer representatives to participate in: (1) proposing standards and policy for quality review, (2) establishing grievance procedures, and (3) promotion of consumer understanding of standards of care;
6. Provide procedural means to adjudicate grievances or disagreements short of legal action, when these cannot be settled at the local level; and
7. Certify approval of those review systems with acceptable performance. (Such a role would be analogous to a bank examiner who periodically ascertains that the system is functioning correctly).

The Health Services Quality Maintenance Agency would be the lead agency to develop guidelines and standards for quality of patient care to be used by hospitals, professional societies, government agencies, third party payers, litigants, arbitrators, consumer advocates, and others. It should be concerned principally with the appropriateness of professional practices, including their cost, as well as with the performance by institutions such as hospitals, health maintenance organizations, and government operated clinics and hospitals. The agency would provide mechanisms for evaluation and adjudication services for third party payers, governmental agencies and litigants. It should be organized in a manner to provide for consumer participation and reaction in the development of guidelines and standards.

To perform its designated functions, the HSQMA would require (at least) the following functional divisions:

A. An *adjudication service* which evaluates, on referral, grievance proceedings or cases under review for failure to meet accepted standards.
B. A *technical assistance—professional liaison division* maintaining collaborative relationships between the HSQMA and all groups representing health professions and institutions which provide health care in Wisconsin.
C. A *public information—reporting division* which informs the public as to: (1) standards of quality, (2) conditions or characteristics of poor service or unethical practice, and (3) means to more efficient use of the health care system.
D. An *examiner system* which examines and approves methods and review practices of local review bodies.

As a non-governmental entity, the HSQMA would be supported by income derived from service provided or from subcontracts from the responsible state agency. Services provided to programs under public funding (Medicaid, Medicare, categorical programs), and to other third party payers would provide the major initial support for the HSQMA organized under public charter as outlined here. Both the HSQMA and local quality review systems could obtain compliance and influence quality by the following mechanisms:

1. Through the strong professional and educational motivation of providers;
2. Through actions which influence access to hospital staff privileges and practice relationships; and
3. Through other actions, (for example, payment of fee, licensure, disclosure of unacceptable practice) defined carefully under conditions of due process.

The Role of Wisconsin RMP

The Wisconsin Regional Medical Program is a quasi-public nonprofit corporation whose policy is determined by a body of representative providers and consumers of health care services. It maintains a close working relationship with educational and research institutions and the providers of health care. It is recognized as an agency which can effectively bring about collaboration among the providers of health care and interrelate the interests of these providers with consumers and government. The Wisconsin RMP is an appropriate agency to promote the development of a health care quality maintenance program for Wisconsin.

The Task Force proposes the following:

1. That the Wisconsin Regional Medical Program should continue to sponsor and support the development of pilot programs in quality surveillance methodology at both the local and state level. Evaluation within such projects of the scope and effectiveness of quality maintenance methodology, including the acceptance of the health care quality maintenance system by providers and consumers, should be utilized as the recommendations within this proposal are implemented.
2. The Wisconsin Regional Medical Program should actively collaborate with the Wisconsin Hospital Association, medical, dental and other health professional societies, and, in general, the providers of health care services to assist individual hospitals and Health Maintenance Organizations, including county medical society foundations, to establish internal quality maintenance procedures which are acceptable and which interrelate with the guidelines and standards developed by the Health Services Quality Maintenance Agency, and which are acceptable as well to Areawide Health Planning Agencies. The Wisconsin RMP would provide consultation to assist the providers to implement quality maintenance procedures.
3. The Wisconsin Regional Medical Program should promote the implementation of educational programs to assure that professional knowledge and expertise is maintained at a level to meet the quality requirements.

The relationships between the HSQMA and the following agencies remain to be established:

1. Governor's Health Policy and Program Council;
2. Statutorily responsible governmental unit (i.e. Division of Health of the Department of Health and Social Services);
3. Data collection unit: How should data be managed at the state level?
   (a) Contract for services with a commercial hospital and practice data reporting service, of which several exist;
   (b) Expand Section of Statistical Services, Division of Health;
4. Professional associations;
5. Areawide Comprehensive Health Planning Agencies;
6. Schools of health sciences;
7. State agency for research and development in health services (as defined by Task Force); and
8. Existing bodies—especially Health Care Review, Inc.

Summary—Quality Maintenance and the Public Interest

A cooperative effort is needed between consumers, providers, and government to promote a system of quality maintenance which benefits society as a whole. It is important that a publicly-accountable system of quality review be developed that is workable, efficient, and consistent. It should reduce rather than increase paper work. It should assist rather than hinder practice and practitioners. It should protect all citizens.

Audit procedures for health services will doubtlessly be implemented on a more comprehensive scale in the years ahead. Data collection, screening, selective case review, and the demands placed on limited manpower resources to accomplish the maintenance of quality must not be duplicated. Review procedures should be held to limits consistent with active participation of practicing health professionals and the demands placed upon them by practice responsibilities.

Any steps to be taken in the immediate future in organizing a quality review capability at the state level will start Wisconsin down a path that will be difficult and costly to modify in coming years. Thus, the deliberations regarding the formation of a quality maintenance and assistance organization at the state level should be undertaken with thoroughness and all available foresight.

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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

AT STATE MEDICAL SOCIETY OFFICES, NOVEMBER 10

Comprehensive Health Planning Conference Set

Interface . . . legitimize . . . providers . . . accountability . . . exploitation . . . minorities—what's *your* frustration quotient when these words are tossed about as part of the jargon of health planning?

A special physicians' conference on comprehensive health planning will be held by the State Medical Society, Friday, November 10, at Society offices in Madison.

Physicians who are members of comprehensive health planning ("B") committees are especially urged to attend this important meeting.

The conference is designed to show physicians how to "get in on the action" when planning decisions are made by committees.

"Psychopolitics" of Planning

Darrell Treffert, MD, Winnebago, will open the day's program by explaining the "psychopolitics" of health planning. Since physicians and other providers are—by law—in the minority on comprehensive health planning committees, knowledge of how to be effective in such meetings is vital. Physicians attending will then discuss the planning process.

Doctors Ben Lawton, Marshfield; George Handy, Madison; and John Hirschboeck, Milwaukee, will be on hand for the second half of the program. They will discuss the future course of health planning, as they see it. No doubt some of this discussion will center around recommendations of the Governor's Health Planning and Policy Task Force.

A proposal to take responsibility for statewide comprehensive health planning out of the Division of Health is now being discussed by the Task Force. Final recommendations are expected at the end of this month.

Resolution Suggested Meeting

This conference on comprehensive health planning was suggested by the Medical Society of Milwaukee County in a resolution passed by the State Medical Society's House of Delegates in May. That resolution asked the State Medical Society to hold "a statewide meeting for physicians participating in local comprehensive health planning agencies" so that they could "discuss matters of mutual interest and exchange information."

Exam. Board Rules on Acupuncture

Acupuncture is illegal in Wisconsin unless the person doing it is properly licensed by the State Medical Examining Board, according to Thomas W. Tormey, Jr., MD, the Board's secretary.

Dr. Tormey said the Board's opinion is that anyone doing acupuncture without such a license would be prosecuted by the Board for practicing medicine and surgery without a license.

He said that the Board came to this conclusion following a New York State ruling that only a licensed physician may practice acupuncture. An acupuncture clinic in New York City was closed in July because the technicians administering the needle therapy were found to be illegally practicing medicine by the New York State Education Dept.

Dr. Tormey said that, according to the Board's ruling, "perforating the skin with sharp objects" is a surgical practice and should be carried out only by one properly licensed to practice medicine and surgery."

In this issue of the WISCONSIN MEDICAL JOURNAL, David N. Goldstein, MD has written a guest editorial on the subject of acupuncture; it appears starting on page 14.

Info on Body Donation

Information on donation of the body—or eyes, or kidneys—is available for anyone who is interested from the State Medical Society.

A reprint on the state anatomical gifts law, as well as uniform donor cards and information from the Kidney Foundation of Wisconsin, will be sent on request by the State Medical Society's public information office.

Oconto County May Have New Approach to Health Services

Packaging Oconto County's health services within one organization has been proposed by American Public Health Association consultants who just completed a study of the area. A nonprofit organization would be formed by local citizens with the aim of improving their health services and perhaps making them more efficient.

If the plan is approved by all involved, Oconto County could serve as a model solution for some of the health delivery problems typical of nonurban areas across the country.

Discussion of the plan, which would set up Oconto County Health Services Organization (OCHSO), is now going on with physicians, dentists, and hospital officials in the area. If their reactions are favorable, the next step would be to incorporate the organization and look for start-up money.

Plan for OCHSO

OCHSO founders would be the local advisory group formed to help in the American Public Health Association study. This includes people from all segments of the community—physicians, dentists, nurses, hospital administrators, farmers, teachers, mayors, attorneys, and others.

According to the plan, OCHSO would:

- **Take the place of the board** of directors of the two hospitals in the county—Oconto Memorial Hospital at Oconto, and Community Memorial Hospital, Oconto Falls.
- **Contract with the county** to operate public health nursing and home health services.
- **Be designated by the County** Board of Supervisors as the local agency to administer the community mental health, mental retardation, alcoholism and drug abuse services programs, and the services for developmental disabilities.
- **Administer emergency** health services including communication and transportation.
- **Be delegated the jobs in the** area now done by town health officers, state environmental health agencies, and Medicaid administrators.

The recommendation also calls for OCHSO to develop and operate new health services: school health, health education, manpower recruitment, occupational health, accident prevention, and manpower recruitment services to people in the county's more remote and isolated areas. If requested, it also could do purchasing, billing, and other administrative services for any area health agency.

The idea now is to start OCHSO with a grant from the government or a foundation and eventually make it self-sustaining. Government moneys and user fees for its services would be a source of income.

Unique Approach

OCHSO was devised as a better way to handle Oconto County's needs than some of the more usual approaches. The County is too small for a traditional health department which can rarely be supported by populations under 75,000. As of 1970, Oconto County had 25,553 people.

The consultants also considered two popular new approaches: foundations for medical care (usually formed by medical societies) and health maintenance organizations. Neither exactly met the needs of the Oconto situation, according to the opinions of the consultants.

OCHSO grew from a probe of rural health manpower shortages by a subcommittee in the state Bureau of Comprehensive Health Planning (CHP).

Gerry M. Halverson, a CHP Bureau planning analyst at the state Division of Health, says that manpower shortages boil down to deciding what services are needed in an area and how many people are required to provide those services.

Consultants Surveyed County

The American Public Health Association study was an attempt to learn what is needed in Oconto County. Because the CHP Bureau didn't have the personnel to do the study itself, American Public Health Association consultants were asked to help. Aiding the consultants in addition to the local advisory group was a state advisory group which included health educators and administrators.

The consultants studied the county's geographic, social, and political characteristics. They also surveyed a sample of Oconto County residents to find out what health and medical care services were believed most needed and wanted. Topping the list of what the citizens want are: more physicians, more dentists, more health clinics, and effective ambulance service.

Mr. Halverson hopes to find out this month if OCHSO will be tried as a way to meet these needs.

State Surgeons of ACS to Meet in Milwaukee

Members of the Wisconsin Chapter of the American College of Surgeons and invited guests will participate in a scientific program Saturday, November 11, at Milwaukee County General Hospital in Milwaukee. The program will feature "Approaches to the Problem of Acute Trauma" and will start at 9:00 a.m. and continue to 3:00 p.m. P. Richard Sholl, MD of Janesville, president of the Wisconsin Chapter, will be the moderator. In addition to Wisconsin Chapter members and residents in the teaching hospitals throughout Wisconsin presenting papers, a visiting speaker from Illinois will participate. He is David R. Boyd, MD, chief of the Division of Emergency Medical Service and Hospital Service of the Illinois Department of Public Health.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

There's Good News and Bad News for Wisconsin's Medical Schools

There was good news and bad news for Wisconsin's medical schools last month.

First the good news.

The University of Wisconsin was awarded its long-awaited federal grant to begin construction of its Medical Center. The Department of Health, Education, and Welfare (HEW) approved UW's request to the tune of $10.7 million.

Less than a week later, the State Building Commission authorized the solicitation of bids for first-phase medical center construction.

$48.5 Million First Phase

The Building Commission approved a total cost of $48.5 million for the first phase. This represented an increase of $3.5 million over previous estimates.

The additional funds will be for increases in the annual number of medical school graduates and hospital beds that were necessary to meet federal requirements for the $10.7 million grant.

Paul L. Brown, director of the Bureau of Facilities Management in the State Administration Department, said the remaining costs of the project would be financed by $21.3 million in state general obligation bonds, $10.5 million in self-amortizing bonding, and $3.5 million in gift funds.

$80 Million Total Cost

The University is awaiting word on another application to the federal government for a $2.3 million grant for a School of Nursing training facility to be built in the Medical Center. Total cost of the Medical Center, if the second phase were approved, would be about $80 million. In addition to the medical and nursing schools, the complex to be built on the west side of the Madison campus, will house a hospital, clinical science departments, and support services.

When the first phase is completed, the UW will be able to graduate 200 physicians a year. This year 129 freshman medical students were admitted to the UW Medical School and this number is expected to gradually increase in coming years.

Now for the bad news.

The Medical College of Wisconsin's bid for a $15 million grant was rejected by HEW.

Officials to Washington

Medical College officials immediately went to Washington to discuss the situation and try to determine what steps to take next.

One of the meetings, with Elliot L. Richardson, HEW secretary, was attended on the Medical College's behalf by Jerris Leonard, a former Wisconsin state senator. Mr. Leonard, an administrator in the U.S. Department of Justice, is an alumnus of Marquette University and continues to take an active interest in Wisconsin affairs. The Medical College formerly was part of the University.

Rep. Clement J. Zablocki (D-Wis), who arranged the meeting with Mr. Richardson, said that the Medical College needs assurance of a future grant if it wishes to obtain a loan.

Loan for $5 Million

HEW has approved a federal guarantee for a loan up to $5 million. Even with the guarantee, Rep. Zablocki indicated, the Medical College would have difficulty in finding construction funds without a firm commitment for a federal grant in the near future.

Mr. Zablocki said HEW justified giving $10.7 million to the UW and nothing to the Medical College on the grounds that the UW had more financial resources available to it. Financial ability to carry through the project is listed among the critical factors in deciding whether grants are made.

The Medical College has a deadline of 1975 to vacate its premises on the Marquette University campus. The college plans to relocate to its site on the grounds of Milwaukee County Institutions in Wauwatosa.

In order to meet the deadline, construction would have to start before the next series of HEW grants to medical schools, not expected until nearly a year from now.

$6 Million in Hand

Following the Washington meetings, the Medical College's fund-raising campaign committee agreed to maintain its organization on a standby basis while alternative plans are being formulated. It is trying to raise $18.4 million for construction of a basic sciences building, an Eye Institute, and operating expenses.

So far, gifts and pledges totaling $6 million are in hand, according to Carlton P. Wilson, co-chairman of the campaign.

Construction Plans Proceed

Of this, somewhat over one million dollars is earmarked for the Eye Institute project, which is proceeding as scheduled.

A statement issued by the College at the end of September said that losing out on the HEW grant does not divert the school from its planned construction.

The statement says: "An enormous project is at stake. The Medical College of Wisconsin recognizes its responsibility in developing the Medical Center of Southeastern Wisconsin."

WHCRI Names Coordinator

Neal B. Baum, Madison, has been named coordinator for Wisconsin Health Care Review, Inc. (WHCRI). He is assisting in the implementation of the review corporation formed last December by the State Medical Society of Wisconsin, the Wisconsin State Dental Society, and the Wisconsin Hospital Association. The WHCRI office is located in the State Medical Society building in Madison.

The corporation arranges for the monitoring of patient care at the request of those who pay for it, such as insurance companies, prepayment plans, government agencies, and individuals.

Before coming to Madison, Mr. Baum worked in Seattle, Wash., and Portland, Ore., in insurance cost control, claims administration, and utilization review.

To Cover Office Calls

New Health Care Insurance Slated

By JOHN NEWHOUSE
Of The State Journal Staff

A new kind of health insurance program that will pay for a wide variety of medical services including routine doctor's office calls will start in Dane County Nov. 1.

A form of the Health Maintenance Organization (HMO), which has attracted national interest, the new pre-paid plan was developed by the Wisconsin Physicians Service (WPS) and the State Medical Society of Wisconsin in cooperation with the Dane County Medical Society.

RAY KOENIG

IN ADDITION to office calls, the plan also will pay for many services performed in the doctor's office, such as X-rays, which are not covered by most existing health insurance plans. Prescription drugs also are covered.

More than 500 practicing physicians in Dane County have signed up to participate in the program.

Negotiations are in progress with employe groups to be covered by the plan, called the Dane County Health Maintenance Program (HMP).

THE GOAL is to sign up 15,000 to 20,000 persons so that results of the experimental program will be statistically significant.

Persons in three groups now insured under WPS — State Medical Society employes living in Dane County; Madison city employes, and Oregon school employes — will soon be offered the option of staying with WPS present plan or going to the new HMP of WPS.

For many, the choice will be easy.

BENEFITS UNDER the new plan will be greater, and it will cost no more.

The odds will be that they will be able to stay with their own doctors, since the majority of Dane County physicians have signed up and will be available to them under the new plan.

The most significant difference under the new plan is the coverage of office calls.

Under most present policies, office calls are paid by the patient, at $6, $7, or $8 per call.

"ONE ADVANTAGE of having the insurance pay for the office calls is that the individual is more likely to consult the doctor early in an illness, when preventative steps can often ward off more serious trouble," says Ray Koenig, executive director of WPS.

"Another advantage is that the doctor, is not faced with the bother and the expense of billing the patient, and WPS is likewise relieved of paper work in connection with bills coming to them."

Another difference is that the new plan pays for X-rays and laboratory work in the doctor's office or as an outpatient in a hospital.

UNDER MOST policies, payment has been made for laboratory tests and X-rays in hospitals only when the individual has entered the hospital as a patient. Complaints have been made that some doctors — as a financial favor to patients — have admitted individuals to hospitals solely to have insurance cover the costs.

"The new plan should cut down on hospital use by treating diseases at an early stage, when the situation can be handled in a doctor's office, and by paying for X-rays and laboratory tests on an out-patient basis," says Koenig.

And he points out that for every $1 paid to a physician for his services, $2 are paid to hospitals, with the average daily cost in a hospital now about $80.

SO WPS hopes it can provide more coverage without charging more because it won't pay as many costly hospital claims. There will be more things done in doctor's offices, and more people covered by WPS will have illnesses detected earlier when treatment is more effective and costs less.

Dane County physicians for several years have been concerned with better methods of delivery of health care. The Nixon Administration has shown an interest in health maintenance organizations, in which groups contract with physicians for health care on a pre-paid basis, and programs such as Kaiser-Permanente have gained national attention.

The Dane County group has wanted to preserve the traditional doctor-patient relationship as much as possible, in which the patient selects his own doctor and the doctor agrees to serve him, and to use local hospitals rather than—as with some plans — build new hospitals and assign patients to available doctors.

LAST DECEMBER, the Dane County Medical Society voted to ask WPS for assistance in formulating the plan. Dane County is the third county group in Wisconsin to try the HMP route. Others are Green and Pierce-St. Croix.

Under the plan, members of employe groups under the age of 65 insured by WPS will receive a list of doctors from which to choose, if they elect the new plan.

They will pay monthly premiums, part of which will go directly to the doctor who accepts them as a patient. The amount will vary with the services offered.

A solo practitioner in a small office, might get from $2 to $3 a month for each person insured, says Donald J. McIntyre legislative counsel of the state society.

In a larger office perhaps a clinic which offers wider services, the fee might range from $3 to $5, he estimated.

IF THE services of a specialist were indicated, such as a neurosurgeon, the insurance would pay this individual on a fee for service basis, taken from a special fund for this purpose.

The program will be closely monitored during the first year, according to McIntyre.

"The Dane County physician wants to know where he's been, and what's happened," says McIntyre.

THE FEE charged, which will be the same as that for the older insurance, will be in effect for the first 12 months, and then be reviewed.

If there is a loss, it will be carried by WPS.

If there is an excess of funds, the excess will be returned to the individuals insured as added benefits or reduced premiums.

IT IS estimated that about 10 per cent of each doctor's practice will involve persons insured under the new plan.

And the statistics gathered in the first year will help to guide the medical profession in extending the plan — or not extending it — to the 600,000 in Wisconsin under WPS or to other groups which seek to join.

The brochure going out to prospective Dane County participants says that, "Services covered by the Dane County Health Maintenance Program are considerably broader than those for families covered by more traditional health benefit plans."

continued on next page

Reprinted, with permission, from the *Wisconsin State Journal*, Sept. 24, 1972

Public Education is Mandatory in Halting Spiraling Health Care Costs, MD Says

Two of the answers to the dilemma of spiraling health care costs are preventive medicine and public education, according to William Grover, MD, Bonduel.

Over-regulation by government simply causes more problems, Doctor Grover told a symposium on health financing, August 17–18, sponsored by the Northeastern Wisconsin Health Planning Council (NEWHPC).

"Education of the public is mandatory in order to give preventive medicine the opportunity to truly succeed," Doctor Grover said.

"Preventive medicine has been expedited by public immunization clinics and non-profit organizations, such as the American Cancer Society in its cancer detection campaigns. But much more needs to be done.

"We must not overlook the capability of the public schools in teaching self-help and preventive medicine, thereby eliminating many unnecessary office and emergency room calls for conditions which in years past were well cared for at home. Ironically, we are more concerned with health insurance than health assurance."

Doctor Grover also said part of the reason for rising health care costs is "thoughtless acceptance of the fallacy" that health insurance can provide "something for nothing."

"I know of no type of insurance other than health insurance in which so many policyholders are so desirous of a claim settlement," he said.

"Third party payment with the common limitation of coverage to inpatient hospital care and exclusion of outpatient diagnostic procedures has resulted in overutilization of hospital facilities and a spiraling increase in health care costs."

Doctor Grover is president of NEWHPC. His talk was followed by panel discussions of federal health programs, national health insurance proposals, and health maintenance organizations.

In a vote taken at the conference, President Nixon's National Health Partnership Act was the most popular of the five major national health insurance proposals, including Medicredit sponsored by the American Medical Association.

NEW HEALTH CARE INSURANCE *continued*

Full Payment

The Health Maintenance Organization program of pre-paid medical insurance will provide full payments for the following services:

Full payment is made for office medical care, examinations, and diagnostic services; well baby, infant, and child care; immunization, injections; Pap smears; X-ray and laboratory services; radiation therapy services; maternity services (if on a family contract), including pre- and post-natal care; consultation services, except at participant's home; surgery, wherever performed; surgical assistants; anesthesia services; in-hospital medical sevrices; services in approved extended care facility; accidental injuries and emergency medical car; ancillary materials, and first 10 hours of psychiatric services in office.

PAYMENT WILL BE MADE at usual, customary, and reasonable charges for nursing service; physical therapist; oral surgery; podiatry or chiropodist, and approved ambulance service.

The same type of full payment will be made for oxygen and rental equipment or administration; radium and radioactive isotopes; artificial limbs and eyes; casts, crutches, and braces; splints and trusses; needles and syringes; colostomy rings, belts, and bags; catheters; elastic stockings; intial cataract lenses after surgery; blood and plasma after first six pints; hospital type bed; wheelchairs; artificial respiration apparatus, and flotation pads.

A part of the drug costs will be paid. The participant pays the first $2 of any prescription, including refills, with the remainder paid by the insurance when the purchase is made through a participating provider.

WHEN THE PURCHASE is made from a non-participating provider, the insurance pays 75 per cent of the cost above the initial $2.

Charges are paid up to the daily room benefit purchased, and paid up to 120 days per admission for each illness.

"We have high hopes for the plan if both physicians and patients understand its concept and cooperate in its operations," says Dr. Gerald J. Derus, president of the Dane County Medical Society.

Hospital Law Seminar Set for Nov. 30–Dec. 1

A seminar on hospital law for three-member "teams" from Wisconsin hospitals—administrator, medical staff representative, and trustee—will be held Thursday, November 30, and Friday, December 1, at Madison's new Sheraton Inn, across from the Coliseum.

The Wisconsin Hospital Association has invited two nationally recognized experts to conduct the two-day program, Attorneys John Horty and Eric Springer, both of Pittsburgh, Pa.

Although administrators, physicians, and hospital trustees can attend as individuals, first preference will be given to three-member teams.

The Wisconsin Hospital Association is sending full program details and registration materials to hospital administrators.

Physicians Learn More About Politicking and Priorities in Health Care Delivery

Over 400 physicians and medical society auxiliary members from all corners of the state attended the State Medical Society's September "update" sessions on health legislation, the Governor's Health Task Force, and peer review.

Twenty-one physicians, legislators, and others spoke and answered questions in Madison, Milwaukee, Appleton, Wausau, La Crosse, and Rice Lake during the tenth annual Wisconsin Work Week of Health.

David Carley, chairman of the Governor's Health Planning and Policy Task Force, tried to allay fears of government control during the Milwaukee program. He stated that the Task Force is not interested in fee controls.

Mr. Carley said the Task Force is defining a public policy on health because no such policy exists. He said he sees the Task Force not as having "all the answers" but rather as "opening up a public dialogue on health care."

"Public Accountability Lacking"

He cited health as "the single most important issue to our citizens." He said, "there is an area for public accountability in the health care field. This is lacking."

Robert R. Cadmus, MD, executive director of the Southeastern Wisconsin Medical Center and a member of the Task Force, cited Carley for bringing attention to health in the state through the Task Force.

Following Mr. Carley's speech, Dr. Cadmus stressed that the mass of information coming from the Task Force must be dealt with according to priorities.

He asked that highest priority be given to those Task Force proposals that would have a real impact on the public's health as reflected by mortality and morbidity statistics. He said administrative reshuffling would have little significant effect.

Dr. Cadmus said the Task Force should give first priority to "a mechanism of ongoing review of health" and said, "the rest of the Task Force items follow this."

"A Pluralistic Approach"

He said, "I would hope that recognition would be given to a pluralistic approach. The problems can't be solved by the stroke of a pen . . . by legislation."

Dr. Cadmus called on the Task Force to see that its list of problems will be reviewed on a continuing basis and not be forgotten.

State legislators on the program told physicians to become actively involved in politics.

Another Task Force member, Paul Glunz, MD (right), talked at the Appleton program. At left is Dr. Derus, who was program moderator at five of the six programs.

MDs' Input Is Valuable

Senator Roger Murphy (R-Waukesha) said at the Milwaukee program that legislators rely on physicians' expertise when deciding how to vote on health legislation.

He told the MDs: "Your input is valuable and essential, for you will be, in most cases, those persons responsible for carrying out the programs we (legislators) create."

He told physicians "the success of your efforts depends upon your ability to intelligently present your argument, reinforced with facts and documented information, and to be persuasive."

"Learn About Politics"

He urged physicians to communicate with legislators, especially person-to-person in political campaigns.

Senator Gerald Lorge (R-Bear Creek), speaking at the Appleton meeting, urged physicians to "take time out to learn about politics." He said medicine's view usually prevails in the legislature when the majority of citizens shares the physicians' views.

Many of the legislators pointed out that, because physicians are really a minority group in the state, they need to be active and well organized in order to be politically successful.

Kicking off the 1972 Work Week in Madison were William Russell, MD, Sun Prairie (left) and state representative Norman Anderson, Madison, Speaker of the Assembly.

Talking about the Governor's Health Task Force at the Milwaukee program were: (left to right) David Carley, Task Force Chairman; Gerald Derus, MD, Madison, State Medical Society President-elect; and Robert Cadmus, MD, Milwaukee, Executive Director of the Medical Center of Southeastern Wisconsin.

Mrs. Janssen, Auxiliary President, Helps Promote Wonderful Wisconsin Week

Mrs. William Janssen, president of the Woman's Auxiliary to the State Medical Society of Wisconsin, is shown here (top of steps, left) with the other members of the aircade organized to promote Wonderful Wisconsin Week. At center is Wisconsin Governor Patrick Lucey. The Aircade made stops in 14 cities August 30–31. Mrs. Janssen recalls that at each stop "it was exciting to hear the name of the State Medical Society mentioned. We were fortunate to be included in the tour; obviously so many groups would like to be. . . . The W-3 tour is a valuable asset."

At the Wausau meeting **Representative Anthony Earl** (D-Wausau) urged physicians to disabuse themselves of the "cherished notions" that something is "good public policy because medicine says so." He contended that good public policy is really what the "prevailing public mood" says it is. He said doctors deceive themselves into thinking that "passive involvement plus a lobbyist is all you need to get the job done." He said it is imperative for individual physicians to "actively support in a political sense those whose point of view is most beneficial to you" and to know the bills and keep in touch with legislators on a regular basis.

Senator Milo Knutson (R-La Crosse) told the Work Week of Health meeting in La Crosse that the physicians' most effective legislative tool is the political system itself. He urged physicians to help the campaigns to put into office those whom they favor. He emphasized that the lobbyist is an important information and communication link, but the real key to a successful legislative program is the reaction of the physician back home plus evidence of real support for medicine's position from the voter constituency.

At Rice Lake, **Representative Alvin Baldus** (D-Menomonie) emphasized the necessity for medicine to assure credibility between its lobbyist and the physicians at home. He said any program is in trouble when it appears to legislators that different views are being expressed by the lobbyist and the members of the organization he represents.

In Madison, **Representative Norman Anderson** (D-Madison), Speaker of the Assembly, gave general background on the legislative process. He said "it is always easier to get legislation defeated than to get it passed." He said this is because passing a bill requires a two-thirds vote in each house of the legislature. Therefore, he said, "if you are interested in passing legislation, get it introduced early".

William T. Russell, MD, Sun Prairie, appeared at all six locations to explain the State Medical Society's legislative program and the Society's Commission on Public Policy, which he heads.

Gerald J. Derus, MD, Madison, president-elect of the State Medical Society, was program moderator for five of the six meetings.

Peer Review and WHCRI

John S. Hirschboeck, MD, Milwaukee, also spoke at all locations. His subject was peer review and Wisconsin Health Care Review, Inc. (WHCRI). Dr. Hirschboeck is the program coordinator of the Wisconsin Regional Medical Program, which has provided some funding to WHCRI.

WHCRI was formed last December by the State Medical Society of Wisconsin, the Wisconsin State Dental Society, and the Wisconsin Hospital Association. Its first project has been a review of medical care of patients under Title XIX (Medicaid) at the three state colonies for the mentally retarded.

The president of WHCRI, Paul Mason, MD, Sheboygan, said, "The peer review committee can protect the professions (from federal intervention) as well as the public."

Other speakers at the six locations included: Doctors George Handy, Gordon Marlow, Arthur Jacobsen, Paul Glunz, Paul Mason, Ben Lawton, Robert McMahon, and R. W. Edwards; and State Medical Society Secretary Earl Thayer.

SMS Hot Line

THE FAMILY PRACTICE PROGRAM at the University of Wisconsin attracted six of this year's University of Wisconsin Medical School graduates. This is the largest number staying at that campus in a single program, according to John H. Renner, MD, family practice director. July 1 a second clinic site in Verona was put into use by the program. The original clinic training site, next to St. Marys Hospital Medical Center, Madison, continues to be used.

SOME PHYSICIANS "CAUGHT IN THE FREEZE" should be granted proper relief, the AMA has told the government. Some highly inequitable situations and harsh economic dilemmas have been brought to the AMA's attention through a special telephone service it set up in August to answer questions pertaining to Economic Stabilization Program regulations. The AMA maintains constant liaison with the federal Committee on the Health Services Industry, apprising it of situations that merit regulatory remedies. The special telephone service for physicians needing assistance is manned by the AMA's Center for Health Services Research and Development. Call: (312) 527-1571, Ext. 434, and ask for Robert Walsh. After closing hours incoming messages are recorded for followup answers.

THE AMA HAS ESTABLISHED an Ad Hoc Advisory Committee on Federal-State Legislation. State Medical Society of Wisconsin Secretary Earl Thayer and six other medical society executives from across the country will serve on the committee that will assist the AMA in devising ways to satisfy the increased need for correlating legislative activities. First meeting of the committee was held Oct. 4 at AMA Headquarters. Discussion topics included the increasing number of federal legislative proposals that are having impact on the way medicine is practiced and the question of federal supremacy in areas that historically have been under state jurisdiction.

THE FRESHMAN CLASS enrollment at both Wisconsin medical schools has jumped this fall, say the schools' registrars. The University of Wisconsin has 129 entering freshmen, compared to 124 last year. The Medical College of Wisconsin has 121 freshmen, up from 111 last year.

ANOTHER LAYER OF GOVERNMENT, "district government" was unanimously rejected by representatives of state's eight areawide comprehensive health planning ("B") agencies at a meeting September 23 in Stevens Point. Idea came from the Governor's Health Task Force. Areawide agencies called it "unnecessary, wasteful, and contradictory to the interests of the people of the state of Wisconsin." They said the Task Force should support local comprehensive health planning efforts instead.

DEBATE ON NATIONAL HEALTH insurance is sure to be spurred this year by the choice of the national intercollegiate debate topic: "Resolved: That the federal government should provide a program of comprehensive medical care for all U.S. citizens." The AMA is providing kits of information to college and university debate teams.

NEWS HIGHLIGHTS

Perinatal Medicine Symposiums Held

The Marshfield Clinic and St. Joseph's Hospital in Marshfield jointly presented a Symposium on Perinatal Medicine September 8. Topics covered included recognition of high-risk pregnancies, hyaline membrane disease, cardiac and surgical emergencies in the newborn, intrapartum monitoring, hypoglycemia, and the like. Speakers included pediatricians, obstetricians, and surgeons of the Marshfield Clinic and nurses of St. Joseph's Hospital.

The Fox Valley Perinatal Center–Neenah, in cooperation with Theda Clark Memorial Hospital, presented the Second Annual Fox Valley Perinatal Conference on September 13 in Neenah. The one-day course focused on various events that affect the fetus and newborn during pregnancy, labor, and delivery. The conference, open to nurses and physicians, specifically dealt with maternal and newborn infections, drug effects on the fetus and newborn, and nutritional problems.

The Wisconsin Perinatal Center–Southcentral Region conducted a High-Risk Pregnancy Course September 28–30 in Madison. The two-and-a-half day conference covered antepartum fetal assessment, specific problems of high-risk pregnancy (hypertension, diabetes, prolonged ruptured membranes, and the like), fetal monitoring, and newborn problems of all types.

Wisconsin Orthopedic Society to Meet

The fall meeting of the Wisconsin Orthopedic Society will be held Friday, October 27, at the Dell-View in Wisconsin Dells. Guest speaker for the meeting, which starts at 10 a.m., will be E. Harvey O'Phelan, MD of Minneapolis who will speak on sports medicine. Doctor O'Phelan has been involved in sports medicine at the University of Minnesota for about 25 years. He has been the physician for the Twins baseball and Lakers basketball teams. He also was one of four physicians accompanying the U.S. Olympic team to Munich this year. He attended the team two weeks before the Olympiad and during its games.

Wisconsin Association for Perinatal Care

The Wisconsin Association for Perinatal Care, in its endeavor to improve the health care of mothers, fetuses, and newborns, has been attracting a wide membership which now totals 196. By profession its membership records show 102 RNs, 85 MDs, 2 nutritionists, 1 social worker, and 6 administrators.

Membership in WAPC is $12.00. Persons wishing to join may make application to: Mary E. Beckman, RN, Maternal and Child Health Section, Wisconsin Division of Health, P.O. Box 309, Madison, Wis. 53701.

To keep WAPC members and other interested persons informed on matters relating to perinatal care, research, and education, the Wisconsin Perinatal Center–Southcentral Region periodically publishes a newsletter. R. A. Barta, MD* of Madison is the Editor; J. M. Schneider, MD* of Madison is Associate Editor. Doctor Barta is Associate Director and Doctor Schneider is Co-Director of the WPC-SR.

Persons interested in receiving the WPC/News should write to: Editor, WPC/News, 202 South Park St., Madison, Wis. 53715.

PHYSICIAN BRIEFS

Jack R. Bartholmai, MD

. . . Beaver Dam, recently became associated with Howard G. Bayley, MD* and R. Sanford Cook, MD* in the practice of radiology. Doctor Bartholmai has joined the medical staff of Beaver Dam Community Hospital, Columbus Community Hospital, and Waupun Memorial Hospital. He graduated from the Marquette School of Medicine in 1968 and served his internship and residency at St. Luke's Hospital, Milwaukee.

Dr. Bartholmai

Dr. Herzog

Paul A. Herzog, MD

. . . Madison, recently became associated with the Jackson Clinic in the Department of Obstetrics and Gynecology. Doctor Herzog graduated from the State University of New York Upstate Medical Center, Syracuse, in 1964. He interned at Johns Hopkins Hospital and served his residency at the University of Wisconsin–Madison.

DuWayne A. Hansen, MD

. . . Seymour, recently became associated with the Hittner Clinic, Seymour. A graduate of the University of Minnesota School of Medicine, he did postgraduate work at the McKenna Memorial Hospital, Sioux Falls, S. D. Doctor Hansen served in the United States Marine Corps for four years and is a member of the American Academy of Family Physicians.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1972

5 Dane County Medical Society Board of Trustees
7 SMS Ad Hoc Committee on Redistricting
11 Dane County Medical Society Utilization Review Plan
13 Special Committee on Licensing
13 Wis. Work Week of Health
14 Wisconsin Work Week of Health (Milwaukee)
14 Ninth Councilor District, Wis. State Dental Society
14 Madison Academy of Internal Medicine
16 Executive Committee of SMS Council
16 SMS Committee on Shortage of Physicians
17 SMS Division on Nervous and Mental Diseases
18 Dane County Medical Society Insurance Advisory Committee
20 Wisconsin Work Week of Health (Appleton)
21 Wisconsin Work Week of Health (Wausau)
23 SMS Commission on Medical Care Plans
25 State Pharmacy Board Exams
27 Wisconsin Work Week of Health (La Crosse)
28 Wisconsin Work Week of Health (Rice Lake)
28 SMS Commission on Scientific Medicine
28 Health Care for Migrant Workers
30 Leadership Training Seminar, Association of Medical Assistants—Wisconsin Society

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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NEWS HIGHLIGHTS . . .

Postgraduate Meeting—Jackson Clinic and Foundation

About one hundred physicians from southern Wisconsin registered for the Fall Postgraduate Meeting of the Jackson Clinic and Foundation, held at the Park Motor Inn, Madison, Sept. 28.

The varied medical program included talks by the following Jackson Clinic physicians: Dr. Edward B. McCabe (pediatrics), "Seizure Disorders in Childhood"; Dr. Harvey F. Hewes (internal medicine), "Recognition of Congenital Heart Disease in Adults and Older Children"; Dr. Paul A. Herzog (obstetrics and gynecology), "Induction of Ovulation Today"; Dr. Harvey L. Barash (orthopedics), "The Orthopedic Heart Transplant"; Dr. Richard F. Baske* (ophthalmology), "Diagnosis of Glaucoma"; and Kathy Garvey, RN, "The Role of the Pediatric Nurse Practitioner."

Dr. Sanford Mackman* (general surgery) moderated a symposium on "Peptic Ulcer," which included the following panel members: Drs. Carl B. Weston* (internal medicine), Blake E. Waterhouse* (gastroenterology), and Klaus D. Backwinkel* (general surgery).

A social hour and dinner for the doctors and their wives in the evening was followed by a program by the Wisconsin Idea Theatre, under the direction of Rob Hankins.

St. Francis Hospital

. . . in La Crosse now has two emergency room physicians who will provide 24-hour service. They are William E. Bender, MD of Manitowoc and William E. Carskadon, MD of San Pedro, Calif.

Volunteer Physicians for Viet Nam

The AMA's Volunteer Physicians for Viet Nam Program recently published an updated Honor Roll of physicians who have participated in the Program.

The Wisconsin list includes 15 physicians: MDs John T. Beno, Green Bay; Thomas P. Chisholm,* Arcadia; Victor S. Falk,* Edgerton (who has served three times); William B. Gallagher,* La Crosse; John A. Grab,* Madison; Samuel B. Harper,* Madison; Charles E. Hopkins,* Madison; Willard G. Huibregste,* Sheboygan; Leif H. Lokvam,* Kenosha; Dominic J. Martinetti,* Hurley; Reynold M. Nesemann,* Kewaunee; Bernard B. Rhomberg,* Wood; Isadore H. Schultz,* Mazomanie; Joseph P. Springer,* Durand; and Jack L. Teasley,* Milwaukee.

The Agency for International Development (AID) has requested the American Medical Association to continue the administration of the VPVN Program. There have been 743 physicians who have served 940 tours since the inception of the VPVN Program in 1965. Approximately 100 volunteers will be required in fiscal year 1973, the AMA states.

To aid in the recruitment effort, an exhibit on the VPVN Program has been developed for display at medical and specialty society meetings. A sound color film also is available. Additional information on these and other aids, pamphlets and brochures is available upon request to: Office of the Program Director, VPVN, AMA, 535 North Dearborn St., Chicago, Ill. 60610.

Ripon Memorial Hospital

. . . recently established an intensive care unit which is interconnected with the intensive care unit of Theda Clark Memorial Hospital in Neenah. Administrators of both hospitals anticipate further shared services as new technology and scientific advancements develop.

Thomas Leach, MD

. . . Hudson, recently joined the medical staff of the Hudson Clinic. He graduated from the University of Minnesota Medical School in 1963 and served his internship at Ancker Hospital, St. Paul, Minn. Prior to joining the Hudson Clinic, he had been in private practice in Babbitt, Minn.

Joseph R. Richter, MD*

. . . La Crosse physician since 1954, recently closed his medical office. Doctor Richter, a past president of the La Crosse County Medical Society, will continue to work part-time at the Western Wisconsin Technical Institute (WWTI) in the student health department. He previously had practiced for 13 years in the community of Chaseburg.

William Oliphant, Jr., MD

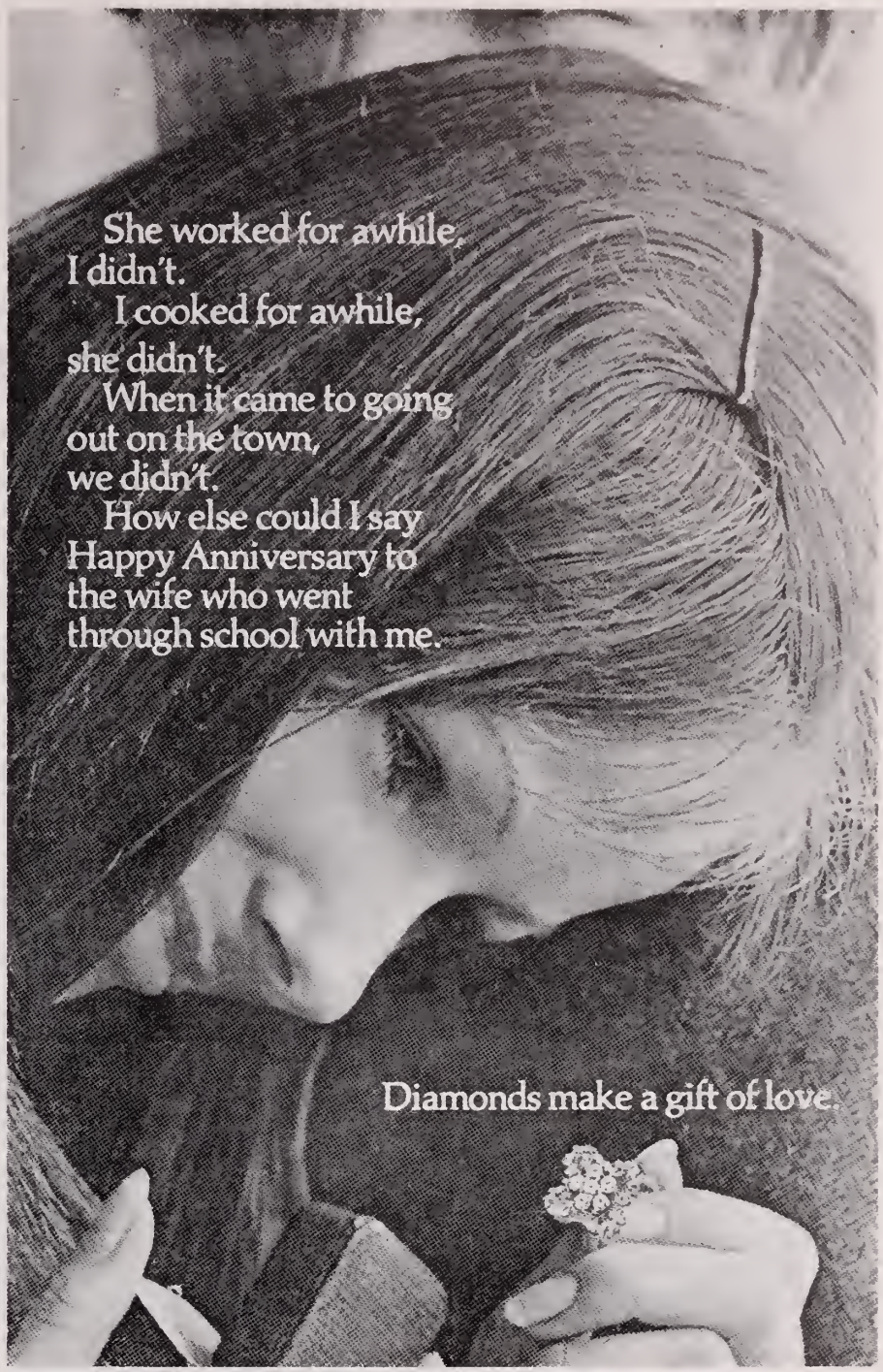
. . . Platteville, recently opened his office for the general practice of medicine. Doctor Oliphant graduated from Loma Linda University Medical School, Loma Linda, Calif.

R. A. Sather, MD

. . . Beaver Dam, recently became associated with the Medical Associates of Beaver Dam. He is a 1968 graduate from the University of Minnesota Medical School and served his internship at Parkland Memorial Hospital, Dallas, Tex. His residency was taken at Oklahoma Medical Center where he was a clinical instructor and an assistant professor in the Department of Community Health.

William W. Young, MD

. . . Taylors Falls, Minn., recently joined the medical staff of the St. Croix Falls Clinic. Doctor Young taught chemistry for eight years and returned to the University of Minnesota Medical School for a degree in Medicine. He served his internship at Bethesda Hospital in Minneapolis.



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PHYSICIAN BRIEFS . . .

Dr. Hewes

Dr. McCabe

Harvey F. Hewes, MD

. . . Madison, recently joined the medical staff of the Jackson Clinic in the Department of Internal Medicine and Cardiology. He graduated from the University of Pittsburgh School of Medicine in 1964 and served his internship and residency at Cleveland Metropolitan General Hospital. Doctor Hewes also had additional training in adult cardiolo-ly and pediatric cardiology at Cincinnati General Hospital and Cincinnati Children's Hospital.

Edward B. McCabe, MD

. . . Madison, recently joined the medical staff of the Jackson Clinic in the Department of Pediatrics and Adolescent Medicine. Doctor McCabe received his medical degree in 1967 from the University of Colorado School of Medicine and served his internship and residency at the University Hospitals, Madison.

David E. Goodnough, MD*

. . . La Crosse anesthesiologist, recently was certified as a Fellow of the American College of Anesthesiologists.

James W. Blevins, MD

. . . recently became director of the Dodge County Mental Health Center. Doctor Blevins graduated from the University of Oklahoma Medical School and was engaged in general practice in California before training in the mental health field at the Menninger Clinic, Topeka, Kan. Prior to coming to Wisconsin, Doctor Blevins was director at the Marin County Mental Health Center in the San Francisco area.

NEWS HIGHLIGHTS . . .

Pain Referral Center Established at UW–Madison

A pain referral center has been established at University of Wisconsin Hospitals in Madison as a new service available to all physicians.

The new clinic is made up of specialists from various medical disciplines to evaluate and treat patients experiencing chronic pain with underlying pathology. To be held every Tuesday afternoon beginning September 19, it is a part of a continuing expansion of clinical facilities offered by University Hospitals.

The clinic will serve as a referral center for patients with organic disease. Although it is recognized that all pain has associated psychological problems and clinic doctors are prepared to cope with these, primarily those patients with known pathology should be referred, the clinic doctors noted.

Appointments may be made, or more information secured by calling Mrs. Glenna Morrison, pain clinic nursing coordinator, at (608) 262–6560.

$20 Million Marshfield Medical Center Planned

Development of a unified medical complex in mid-Wisconsin moved a step closer to reality when it was announced in mid-September that the extensive laboratory facilities of the Marshfield Clinic and St. Joseph's Hospital would be joined together.

David Ottensmeyer, MD,* Marshfield Clinic president, said, "This joint lab development adds purpose to the Marshfield Clinic's previously-stated intention to move its facilities to a site adjacent to St. Joseph's Hospital."

Construction will begin next spring on the $20 million building phase of the medical complex which, when completed, will house 150 physician specialists, a referral hospital of approximately 500 beds and the new laboratory facilities. Target date for completion is 1975.

At present, the Marshfield Medical Center consists of the Marshfield Clinic, a 114-physician, multi-specialty group practice; St. Joseph's Hospital, a 416-bed facility owned and operated by the Sisters of the Sorrowful Mother; and the Marshfield Clinic Foundation for Medical Research and Education.

WRMP Wins $1,500 National Award

The Wisconsin Regional Medical Program (Wisconsin RMP) received a Gerard B. Lambert Award and $1,500 for developing innovative programs in health designed to improve patient care or reduce health costs. More than one thousand ideas and programs were reviewed before selecting three cash award winners.

Of the ten awards presented, the award to the Wisconsin RMP was the second highest presented. It is the first time a Regional Medical Program has received the coveted award.

The Wisconsin RMP is one of 56 similar programs in the country dedicated to the improvement of the health care delivery system through the coordination of facilities and manpower especially in the areas of heart disease, stroke, cancer, kidney disease and emergency health services.

The award was presented to the Wisconsin RMP for its development of a project—"Nurse Utilization: A Patient Care Systems Project"—directed by Janet Kraegel and Virginia Schmidt of Milwaukee. The project was located at St. Mary's Hospital, Milwaukee, and received the cooperation of many hospital personnel and educators from throughout the state.

The University of Wisconsin–Milwaukee collaborated with the Wisconsin RMP in carrying out the project. It has incorporated many of the features of the project in its nursing curriculum. □

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Justin D. Leahy, MD*

. . . Park Falls, closed his office Aug. 1, 1972, after 50 years of medical practice in the Butternut and Park Falls area. He graduated from Loyola University School of Medicine, Chicago, in 1915, and served his internship at Alexian Brothers Hospital in Chicago. He was called into service during World War I and served with a British Medical Detachment in Europe. He received the British Military Cross for his service on the Western Front. Doctor Leahy settled in the Butternut area in 1919 and in 1925 moved to Park Falls where he purchased the Park Falls Hospital. Active in community affairs, Doctor Leahy also served as secretary and president of the Price–Taylor County Medical Society. He is a member of the "50 Year Club," served as councilor of the thirteenth district for 12 years, was speaker of the House of Delegates in 1958, and served on the State Medical Society's Committee on Grievances for many years.

Henry S. Ashe, MD*

. . . is reported to have played a major part in the decision of S. Howard Young to will an estimated $20 million estate to the Lakeland Memorial Hospital in Woodruff to build a Howard Young Medical Center. It has been reported that Mr. Young's admiration and respect for Doctor Ashe was a stabilizing force in the eventual bequest of Mr. Young who visited the area many times in retreats from New York City where he was an art curator. Lakeland hospital's board of directors and the community it serves have been in a state of frenzied joy since the announcement was made.

Teodoro M. Ramos, MD*

. . . has been named medical director of the Ripon Cerebral Palsy and Rehabilitation Center. A 1962 graduate of Far Eastern University, Institute of Medicine, Manila, The Philippines, Doctor Ramos served a rotating internship at Deaconess Hospital, Milwaukee; MacLaren General Hospital and Hurley Hospital, Flint, Mich. In 1971 Doctor Ramos established a practice in general surgery and medicine at Ripon.

Dr. Leahy and Great Grandson

Edward G. Vogel, MD

. . . Green Bay, has joined the medical staff of the West Side Clinic, Green Bay. He is a graduate of Stritch School of Medicine, Loyola, and interned at St. Mary Hospital, San Francisco. Doctor Vogel completed his residency at the University of California, San Francisco and recently completed two years with the United States Navy.

Derward Lepley, Jr., MD*

. . . Milwaukee, recently was one of the guest speakers at the symposium sponsored by Watertown Memorial Hospital on September 27. The subjects of the one-day symposium were prolonging life, the medical management of the terminally ill patient, and the issue of organ transplants.

Jeffrey Schwab, MD

. . . Watertown, recently became associated with the staff of Medical Associates of Watertown. He graduated from the University of Minnesota Medical School in 1971 and served his internship at Milwaukee County General Hospital.

Mohammed Badruddoja, MD

. . . Watertown, recently became associated with the Coron Clinic, Watertown. Doctor Badruddoja, a graduate in medicine and surgery of Medical College of Dacca, Bangladesh, had practiced in Canada and in Mason City, Iowa. He is a board certified surgeon and a fellow of the Royal College of Surgeons of Canada and of the International College of Surgeons.

Salvador Del Rosario, MD

. . . Grafton, recently began his internal medicine practice in the Grafton Medical Clinic. Doctor Del Rosario graduated from Far Eastern University and completed two internships, one at Deaconess Hospital, Milwaukee, and another at St. Luke's in The Philippines. His residency was taken at Milwaukee County General Hospital.

William S. Middleton, MD*

. . . former VA Chief Medical Director (1955–63) and Dean Emeritus of the University of Wisconsin Medical School, Madison, was the featured speaker at the September 7 dedication of the new $2.4 million research building at the Veterans Administration Hospital in Washington, D.C. Doctor Middleton is now serving as a special VA Consultant in Research and Education.

Mortimer M. Bortin, MD*

. . . recently received a two-year research grant of $85,582 from the American Cancer Society to develop a successful model for the treatment of experimental leukemia which will be feasible for the treatment of human leukemia. This was reported as the largest single research grant awarded a Milwaukee scientist. Doctor Bortin is director of the May and Sigmund Winter Research Laboratory at Mount Sinai Medical Center and clinical professor of medicine, Medical College of Wisconsin, Milwaukee.

Harold P. Rusch, MD

. . . has been appointed director of the new Wisconsin Clinical Cancer Center at the University of Wisconsin–Madison Center for Health Sciences. Regents of the UW System approved his appointment at a meeting in early September. An internationally-known research authority and member of President Nixon's National Cancer Advisory Board, Doctor Rusch has been director of the McArdle Memorial Laboratory for Cancer Research in Madison since 1946. As director of the new clinical cancer program Doctor Rusch will head a multidisciplinary effort which will bring together all aspects of dealing with the disease. The major areas include care of patients, the teaching of professionals who treat cancer patients, and research in detecting the disease and curing it.

J. Francis Wilkinson, MD*

. . . Oconomowoc, recently was honored for his 50 years of medical practice in Oconomowoc. Doctor Wilkinson graduated from Marquette University School of Medicine in 1921 and served his internship at Milwaukee County General Hospital. He began his medical practice in 1922 with his father, the late M. R. Wilkinson, MD. Doctor Wilkinson is still active in the Wilkinson Clinic along with his two brothers, MDs John* and Philip.* A color portrait of Doctor Wilkinson by Peter Theobald, MD* president of the Clinic, was presented and will hang in a new wing of the clinic which was named the Dr. J. Francis Wilkinson Addition.

John W. Utrie, MD*

. . . former Green Bay physician, recently became associated with the Bump Medical Group, Rhinelander. A 1959 graduate of the Medical College of Wisconsin, he served his internship at Charles Miller Hospital, St. Paul. Prior to joining the Bump Medical Group, he was associated with the Beaumont Clinic, Green Bay. □

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SECTION OPHTHALMOLOGY

OCTOBER 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

TREATMENT OF RETINOBLASTOMA

Doctors James T. Patten and Thomas M. Aaberg of Milwaukee have written an article on "Treatment of Retinoblastoma" which appears in this issue as the COMMENTS ON TREATMENT feature in the scientific section starting on page 236.

WIS.–U. MICH. SOCIETY OF O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will meet in Wausau October 21 at the Midway Motor Lodge. Speakers will be Doctors Thomas M. Aaberg and Robert A. Hyndiuk, Milwaukee, and Dr. Morton F. Goldburg of Chicago.

DIABETIC RETINOPATHY STUDY

The National Eye Institute has recently sent out a news release concerning the initiation of a controlled clinical trial of photocoagulation in the treatment of diabetic retinopathy. This release has been the basis of newspaper articles in many cities across the country, and ophthalmologists may anticipate the possibility of questions from their patients. The following information is provided to help answer such questions and to notify all Wisconsin ophthalmologists, and other physicians as well, that the Diabetic Retinopathy Clinic at University Hospitals in Madison is now recruiting patients for this project. The explanation of the project prepared by the National Eye Institute for laymen is summarized below.

Patients are now being enrolled in a nationwide cooperative research study to evaluate new methods of treating diabetic retinopathy—a progressive disorder of the blood vessels of the retina stemming from diabetes, and a leading cause of blindness in this country. Supported by grants from HEW's National Eye Institute, a component of the National Institutes of Health, the ten-year, $5 to 7 million study will eventually involve over 1,800 patients at 16 clinical centers across the country.

The mechanism underlying diabetic retinopathy is unknown, but the condition seems to involve progressive impairment of the retinal circulation.

The primary objective of the cooperative study is to determine whether photocoagulation helps preserve vision in patients with diabetic retinopathy. In some cases the light applications are made directly over the patches of new vessels in an attempt to coagulate and occlude them, while in others the applications are scattered in a checkerboard pattern over large areas of the retina in the hope there will be an indirect beneficial effect on untreated areas of the retina.

Although photocoagulation has been used extensively in the treatment of diabetic retinopathy in recent years, its true value has not been clearly documented. Furthermore, the several available methods of photocoagulation have not been tested against each other. For this reason patients in the NEI-supported study will be randomly divided into three groups. One group will be treated with white light from the Xenon arc photocoagulator, a second group with the Argon laser, which generates a fine but intensely brilliant blue-green beam of light, and a third group with a combination of these two methods. Patients with roughly symmetrical retinopathy will be selected and one eye of each patient assigned at random to one of the above treatment techniques.

Initially every patient will be given an extensive eye examination and a comprehensive medical examination. Photographs of the retina will also be taken before treatment to provide objective evidence of the presence of diabetic retinopathy and to classify the stage of the disease. Follow-up photographs will be taken to assess the effects of treatment. Each patient will be followed for five years, during which time he will have several follow-up examinations.

To be eligible for entry into the study, a patient must have best corrected visual acuity of 20/100 or better in each eye. The retinopathy must be in the proliferative or severe preproliferative stage, but not have reached the late "burned out" stage. The severity of the retinopathy must be sufficiently similar in the two eyes so that the clinician's best guess is that each has a roughly equal chance of benefit from photocoagulation, so that random selection of the eye to be treated is justified. It is anticipated that screening of 3 to 10 patients will be necessary for every one found suitable for entry into the study. A detailed description of the project including a realistic estimate of the risks involved (to the treated eye from treatment and to the untreated eye from withholding treatment) is presented to each patient considering entry into the study, so that his consent may be truly informed.

Matthew D. Davis, MD, Chairman of the Department of Ophthalmology at the University of Wisconsin, Madison, is chairman of the committee of senior clinical investigators who have planned and are guiding the project and is also directing the central facility for grading of fundus photographs from all participating clinical centers. A coordinating center for the study has been established at the University of Maryland in Baltimore.

The University of Wisconsin's participation as a clinical center in this project is directed by Frank L. Myers, MD, assisted by MDs George H. Bresnick, Guillermo de Venecia, and James Harris. Ms Ann Shrake is coordinator of the project and can be reached at 608/262–1994 or 262–1300 for further information and patient appointments. □

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OBITUARIES

Edward L. Jenkinson, MD, 80, retired radiologist of Minocqua, Wisconsin, and Bel Aire, Fla., died July 30, 1972 in Rhinelander.

Born on Feb. 25, 1892 in Rhinelander, Doctor Jenkinson graduated from St. Louis University School of Medicine and did postgraduate work at Cornell University and in Germany and France. He served in the United States Army during World War I. He became associated with St. Luke's Hospital, Chicago, and became senior director of the Radiology Department until his retirement in 1958. Doctor Jenkinson also was a full professor and chairman of the Department of Radiology at Northwestern University Medical School.

Surviving are his widow, Helen; and one daughter, Mrs. James (Carol) Bolger of Waukesha.

Milo T. Erickson, MD, 73, former Iowa County physician died Aug. 7, 1972 in Madison.

Born Dec. 26, 1899 in Cameron, Doctor Erickson graduated from Northwestern University School of Medicine and served his internship at Cook County General Hospital, Ill. He had been a Madison resident since 1945.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ruby; one daughter, Mrs. Dona Bartel, Minneapolis, Minn., and one son, Dr. Milo Rodney Erickson, Green Bay.

Evan A. Miller, MD, 76, Winter Haven, Fla., died Aug. 9, 1972 in Winter Haven.

Doctor Miller was born in Wisconsin and practiced in Chicago, Ill. He was a 50-year member of the Illinois Medical Association.

Ramon L. Lange, MD, 48, professor of medicine at the Medical College of Wisconsin, died Aug. 20, 1972 in Elm Grove.

Born June 9, 1924 in Superior, Doctor Lange graduated from Duke University School of Medicine and served his internship and residency at Duke Hospital and Salt Lake General Hospital. He was an assistant professor of medicine at the University of Utah before coming to the Medical College of Wisconsin in 1961.

He served in the Army in World War II and in the United States Air Force during the Korean War. Doctor Lange was a member of the American and Wisconsin Heart Associations, the Central Society for Clinical Research and the American Society of Clinical Investigation.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Beverly; and three sons, Jamie and Gregory, Elm Grove, and David of Milwaukee. □

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF AUGUST 11, 1972

NEW MEMBERS

Charnecki, George, 825 E. Washington, West Bend 53095
Lemper, P. David, Osceola 54020

CHANGE OF ADDRESS

Ameduri, Ardow R., 2450 W. Huisache Ave., San Antonio, Tex. 78228
Boomer, Robert B., Route #1, Green's Coulee, Onalaska 54650
Chapman, Marvin J., 5907 Winnequah Rd., Madison 53716
Dawes, Robert B., 112 Grover St., Warrensburg, Mo. 64093
Derse, Fabian R., 3161 N. 77th St., Milwaukee 53222
Dettmann, Norbert F., 6538 Washington Circle, Milwaukee 53213
Enders, Lawrence J., P.O. Box 4186, McChord AFB, Wash. 98438
Englund, Stanley A., 725 American Ave., Waukesha 53186
Garay, Fema So, 743 N. Montgomery St., Port Washington 53074
Garnett, Gordon M., P. O. Box 4256, Madison 53711
Geldner, Michael M., 240—1st St., Neenah 54956
Halbert, Helen E., 1402 N. Roosevelt Ave., Cherokee, Iowa 51012
Holmstrom, Robert D., 2809 N. 7th St., Sheboygan 53081
Johnson, W. Dudley, 7635 W. Oklahoma Ave., Milwaukee 53215
Klutzow, Friedrich W., Route #4, Box 865, Excelsior, Minn. 55331
Krautkramer, Ronald, 2460 Penn Ave., North Muskegon, Mich. 49445
Lulloff, Rolf S., U. S. Walson Army Hospital, Fort Dix, N. J. 08640
Manz, Walton R., 102 East Grand Ave., Eau Claire 54701
Nefches, Michael S., 5899 Hillside, Seminole, Fla. 33542
Pier, Philip E., 506 East Longview Dr., Appleton 54911
Pineda, Honorio G., 406 Main St., Menomonie 54751
Prentice, John W., 206—6th Ave., West, Ashland 54806
Pulito, Frank J., 9035 Watertown Plank Rd., Milwaukee 53226
Ramos, Teodoro M., P. O. Box 187, Ripon 54971
Randall, Murray W., P. O. Box 9742, Colorado Springs, Colo. 80909
Schuler, William M., P. O. Box 39, Ripon 54971
Struthers, James L., 812 E. 18th St., Marshfield 54449
Suechting, Ralph L., 240—1st St., Neenah 54956
Trangsrud, Howard A., P. O. Box 4133, Milwaukee 53201
Utrie, John W., 1020 Kabel, Rhinelander 54501
Viste, Kenneth M., Jr., 240—1st St., Neenah 54956
Wilson, Jeffrey W., 316 E. Silver Spring Dr., Milwaukee 53217

DEATHS

Parks, John L., nonmember, July 5, 1972
Traut, Eugene F., nonmember, July 15, 1972
Schneider, Chester C., Milwaukee County, July 16, 1972
Wilkinson, Donald C., Waukesha County, July 19, 1972
Baumle, Benjamin J., Milwaukee County, July 20, 1972
Babbitz, Albert L., Milwaukee County, Aug. 6, 1972 □

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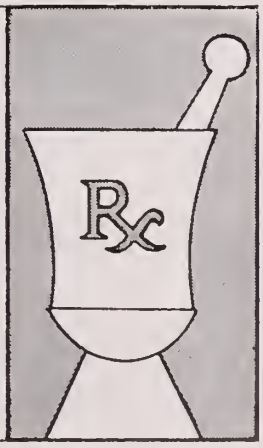

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

A Decade of Progress—The United States Army Medical Department 1959–1969. Editor-in-Chief, Col. William S. Mullins, MSC, USA. Office of the Surgeon General, Department of the Army, Washington, D. C. 1971. Superintendent of Documents, Government Printing Office, Washington, D. C. 20402. 214 pages. Price: $2.25.

Textbook for the Orthopaedic Assistant. By F. Richard Schneider, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 198 pages. Price: $10.75.

Technology and Interpretation of Nuclear Medicine Procedures. By D. Bruce Sodee, MD and Paul J. Early. The C. V. Mosby Co., St. Louis, Mo. 1972. 516 pages. Price: $22.90.

Civilization & Science. A Ciba Foundation Symposium. CIBA Pharmaceutical Company. Division of CIBA-GEIGY Corp., Summit, N. J. 07901. 1972. American Elsevier Publishing Co., Inc., 52 Vanderbilt Ave., New York, N. Y. 10017. 227 pages.

Review of Medical Microbiology. By Ernest Jawetz, Joseph L. Melnick and Edward A. Adelberg. Lange Medical Publications, Drawer L, Los Altos, Calif. 94022. 1972. 518 pages. Price: $8.00.

FDA Interim Index to Evaluations Published. U. S. Dept. of Health, Education, and Welfare, Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 1971. 181 pages.

Modern Treatment. Vol. 9, No. 1. *The Treatment of Edema,* guest editor, Richard H. Kessler, MD. *Skin Stigmata of Adolescent Drug Addiction,* A. W. Young, Jr., MD, Elaine V. Digrande, MD and Lawrence T. Wagers, MD. *The Pharmacology and Clinical Use of Lidocaine as an Antiarrhythmic Drug—1972,* Donald C. Harrison and Edwin L. Alderman. Harper & Row, Publishers, Inc., 49 East 33 St., New York, N. Y. 10016, February 1972. Issued quarterly. Price: $20.00 per year.

Practice of Surgery—Current Review. Vol. I. By Walter F. Ballinger, MD and Theodore Drapanas, MD. 1972. The C. V. Mosby Co., St. Louis, Mo. 321 pages. Price: $23.50

Symposium on Aesthetic Surgery of the Face, Eyelid, and Breast. Editors, Frank W. Masters, MD and John R. Lewis, Jr., MD. Proceedings of the Symposium of the Educational Foundation of the American Society of Plastic and Reconstructive Surgeons, Inc., and the American Society for Aesthetic Plastic Surgery, Inc. The C. V. Mosby Co., St. Louis, Mo. 1972. 222 pages. Price: $35.50

A Synopsis of Contemporary Psychiatry, 5th ed. By George A. Ulett, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 367 pages. Price: $10.90

Current Clinical Studies and Patient Referral Procedures. The Clinic Center, National Institutes of Health, Bethesda, Md. 20014. US Dept of HEW, Public Health Service. DHEW Publication No. (NIH) 72–217. Revised August 1972.

Urinary Tract Infection and its Management. Edited by Donald Kaye. 1972. The C. V. Mosby Co., St. Louis, Mo. 290 pages. Price: $22.50

Marihuana and Health. Second Annual Report to Congress from The Secretary of Health, Education, and Welfare. May 1972. US Government Printing Office, Washington, D.C. 150 pages

Confessions of a Gynecologist. By Anonymous MD. Doubleday & Company, Inc., Garden City, N. Y. 1972. 319 pages. Price: $7.95

Synopsis of Surgery, 3rd edition. By Richard D. Liechty, MD and Robert T. Soper, MD. 1972. The C. V. Mosby Co., St. Louis, Mo. 1108 pages. Price: $15.50

Synopsis of Pathology, 8th edition. By W. A. D. Anderson, MA, MD, FACP, FCAP, and Thomas M. Scotti, AB, MD. 1972. The C. V. Mosby Co., St. Louis, Mo. 1076 pages. Price: $13.95

Pollution, Its Impact on Mental Health. National Clearinghouse for Mental Health Information, National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 20852. Superintendent of Documents, US Government Printing Office, Washington, D.C. 20402. 81 pages. Price: $.45

Lipids, Malnutrition and the Developing Brain. Ciba Foundation Symposium. 1972. Published by Associated Scientific Publishers, P. O. Box 3489, Amsterdam, and 52 Vanderbilt Ave., New York, N. Y. 10017. 326 pages.

Peptide Transport in Bacteria and Mammalian Gut. Ciba Foundation Symposium. 1972. Published by Associated Scientific Publishers, P. O. Box 3489, Amsterdam, and 52 Vanderbilt Ave., New York, N. Y. 10017

Carbon–Fluorine Compounds. Ciba Foundation Symposium. 1972. Published by Associated Scientific Publishers, P. O. Box 3489, Amsterdam, and 52 Vanderbilt Ave., New York, N. Y. 10017

Medicine in a Changing Society. By Lawrence Corey, MD, Steven E. Saltman, MD and Michael F. Epstein, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 228 pages. Price: $6.50.

BOOK REVIEWS

The Face in Genetic Disorders

By Richard M. Goodman, MD and Robert J. Gorlin, DDS. The C. V. Mosby Company, St. Louis, Mo. 1970. 169 pages. Price: $19.00.

This is a well-written and very useful book. The material is presented succinctly, with complete photographic documentation, useful references, and a good historical perspective for each of the syndromes described. In addition, this book contains an excellent introductory chapter on basic genetics and counseling which could serve as a useful refresher course in human genetics for both general clinicians and medical students.

This book contains a number of syndromes not described in an earlier but similar publication (Gellis and Feingold's *Atlas of Mental Retardation Syndromes,* HEW, 1968), although the *Atlas* has others not covered here. However, the two books used together would provide an excellent coverage of the field.

My only criticism of this book is that it lacks a good cross index listing the syndromes alphabetically by all of the names which may be applied to them. Although the book is not so long that one will not eventually find the material he seeks, the fact that there are so many different names for some of the syndromes puts the burden of knowing all possible designations on the reader. Thus, for example, the mucopolysaccharoidoses are found under Hunter's Syndrome, Hurler's Syndrome, Sanfilippo, etc., but the reader must know these names to find them. If there is another printing of this book, it would be very helpful to add such an index, and would require only another two pages or so.

In summary, I find this to be an excellent, useful and convenient book, with a format that lends itself to teaching and demonstration purposes.—LORRAINE F. MEISNER, PhD

Ellison's Atlas of Surgery of the Stomach and Duodenum

By Larry C. Carey, MD, and Robert H. Albertin. The C. V. Mosby Company, S. Louis, Mo. 63103. 1971. 165 pages. Price: $24.50.

This *Atlas of Surgery of the Stomach and Duodenum* is a detailed step-by-step description of the numerous operations listed. The illustrations are superbly done by Mr. Robert H. Albertin and the placement of the descriptive text opposite the illustrations allows one to minutely examine the drawings and at the same time have available the excellent descriptions in the text.

This atlas should be of benefit to anyone doing upper gastrointestinal surgery, particularly those in the learning stage as residents or for people doing occasional gastrointestinal surgery. In addition, it is an excellent source for review for the experienced surgeon who may be interested in seeing techniques slightly different from his own well illustrated and described.

This volume is superbly done and I do not hesitate to recommend it highly to those interested in gastrointestinal surgery.—KENNETH E. LEMMER, MD □

FOR RENT: OFFICE SPACE IN Waunakee, 1200 sq. ft., new dental building. Ten minutes from Madison. Contact S. A. Karls, DDS, 400 2nd St., Waunakee, Wis. 53597. Tel: 608/849–4199. 10tfn

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1972 WISCONSIN

Oct. 27: Wisconsin Orthopedic Society fall meeting, Dell-View, Wisconsin Dells.

Nov. 1: Family Practice Conference, Neenah (see details elsewhere in box).

Nov. 2: Family Practice Conference, Wausau (see details elsewhere in box).

Nov. 3: Symposium on Aortic Aneurysmal and Peripheral Vascular Surgery, Division of Thoracic and Cardiovascular Surgery, UW—Madison.

Nov. 8: Family Practice Conference, Eau Claire (see details elsewhere in box).

Nov. 10–11: Wisconsin Neurological Society, Wisconsin Dells.

Nov. 11: Conference on Practical Aspects of Gynecologic Endocrinology and Chemotherapy in Gynecologic Oncology, sponsored by the Dept of Gyn–Ob, Lutheran Hospital of Milwaukee, at Holiday Inn Central, Milwaukee.

Nov. 11: Wisconsin Chapter—American College of Surgeons, Milwaukee County Hospital, Milwaukee. Edward Bachhuber, MD, program chairman. Speaker: Dr. David Boyd of Illinois.

Nov. 11: Pediatric Symposium sponsored by Marshfield Clinic Foundation, in Marshfield.

Nov. 11: Wisconsin Society of Pathologists, Lutheran Hospital of Milwaukee, Milwaukee.

Nov. 15: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Dec. 14: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

1972 NEIGHBORING STATES

Nov. 8–10: Internal Medicine Grand Rounds, American College of Physicians, Mayo Clinic, Rochester, Minn. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Nov. 10: 1972 Workshop of the Institute of Medicine, Ambassador West Hotel, Chicago.

Nov. 15: Workshop on the Problem-Oriented Medical Record, Univ of Iowa, Iowa City.

Nov. 24–25: Conference on Radiology in Otolaryngology and Ophthalmology, Chicago, Ill. Info: Galdino E. Valvassori, MD, Radiology Dept., Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680.

Nov. 25: Minnesota Regional Meeting, American College of Physicians, Radisson Hotel, Minneapolis, Minn. Info: Howard L. Horns, MD, 100 Melbourne Ave. SE, Minneapolis, Minn. 55414.

Dec. 8–9: New Directions in Sports Medicine Symposium, Univ of Iowa, Iowa City.

1972 AMA

Nov. 26–29: AMA Clinical Session, Cincinnati, Ohio.

1972 OTHERS

Dec. 2–7: Thirty-First Annual Meeting of the American Academy of Dermatology, Americana Hotel, Bal Harbour, Fla. Info: Frederick A. J. Kingery, MD, 2250 Northwest Flanders St., Portland, Ore. 97210.

1973 WISCONSIN

Jan. 17: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Feb. 15: State Medical Society In-Depth Teaching Program, Madison General Hospital, Madison.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Apr. 11: Family Practice Conference, Neenah (see details elsewhere in box).

Apr. 12: Family Practice Conference, Wausau (see details elsewhere in box).

Apr. 18: Family Practice Conference, Eau Claire (see details elsewhere in box).

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May 9: Family Practice Conference, Neenah (see details elsewhere in box).

May 10: Family Practice Conference, Wausau (see details elsewhere in box).

May 16: Family Practice Conference, Eau Claire (see details elsewhere in box).

1973 NEIGHBORING STATES

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Feb. 7–9: Twenty-Fifth Annual Meeting American Academy of Occupational Medicine, Royal Orleans Hotel, New Orleans, La. Info: James M. MacMillan, MD, Medical Director, Reynolds Metals Co., 6601 W. Broad St., Richmond, Va. 23218.

Mar. 10–11: Provocative Allergy Course, Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. Info: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609.

Mar. 15–16: 22nd Annual Postgraduate Course in Pediatrics of The University of Texas Medical Branch, Galveston, Tex. Info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Tex Medical Branch, Galveston, Tex. 77550.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

Postgraduate Medical Seminar Cruise. Jan. 5–22, 1973. Reservations now being accepted by Department of Postgraduate Medicine, Albany Medical College, New York. An 11-day cruise from New York aboard the luxurious and distinguished ship "Gripsholm" of the Swedish American Line. Ports of call include: St. Maarten, Martinique, Barbados, St. Vincent, Grenada, Curacao, Antigua, and St. Croix. Faculty of the Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in pediatrics, psychiatry, surgery, hematology, and physiology. Request has been made for continuation study credit by the American Academy of Family Physicians. For info write to: Frank M. Woolsey, Jr., MD, Dept of PG Medicine, Albany Medical College, Albany, NY 12208.

Workshop on the Problem-Oriented Medical Record will be held at Iowa Memorial Union on the University of Iowa campus Wednesday, November 15.

This one-day program will provide information about the problem-oriented medical record (POMR), and actual small-group practice sessions in developing and writing such records. The lectures will benefit those who know little about the POMR, as well as those who have begun to use this new approach and need assistance, and will include information on how to summarize old records and convert them to the POMR.

For registration info, write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240.

Symposium on Aortic Aneurysmal and Peripheral Vascular Surgery will be held at the University of Wisconsin—Madison, Friday, November 3. Problems relating to a variety of vascular diseases will be discussed with diagnostic and therapeutic material presented.

Program will be moderated by Dr. Donald Kahn, Professor of Surgery, Chairman of the Division of Thoracic and Cardiovascular Surgery.

Participants include Dr. William Fry, Prof of Surgery, U of Mich, and Dr. Richard Kraft, Chief of Surgery, St. Joseph's Hospital, Ann Arbor, Mich., and members of the Dept of CV Surgery at UW—Madison.

In conjunction with program, the Thoracic and CV Surgery Dept of UW—Madison also announces the opening of a new Vascular Disease Outpatient Clinic. Complex problems related to vascular disease of the thoracic and abdominal aorta and peripheral arteries will be evaluated by staff physicians with the aid of newer diagnostic equipment (i.e. Doppler flow probe). Tuesdays, from 1:00 p.m. to 4:00 p.m. is regularly scheduled clinic day and emergencies and urgent consults are seen at any time.

Inquiries regarding symposium and clinic should be directed to Thoracic and Cardiovascular Surgery Department, 608/262–2146.

New Directions in Sports Medicine will be the title of a two-day symposium to be held at the Medical Alumni Auditorium on the University of Iowa campus Friday and Saturday, December 8 and 9.

Among topics of Friday's lectures will be "Coronary Blood Flow and Myocardial Oxygen Consumption During Exercise," "Muscle Fiber Types in Neuromuscular Control," "Biochemistry of Muscle," and "Liver Function During Exercise."

Saturday's lectures will include discussions of prevention of heat injuries in endurance running, artificial turf injuries, new considerations for trainers, and new dimensions in exercise prescription. Small group discussions will follow.

Guest faculty members for the symposium will be Lawrence B. Oscai, University of Illinois, Chicago; Loring B. Rowell, University of Washington, Seattle; and Neal Tremble, Drake University, Des Moines.

For registration information, write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240.

Provocative Allergy Course. A practical course in the technique of intradermal provocative food testing and food injection therapy will be offered Saturday and Sunday, March 10–11, 1973 at the Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. 36601.

Course will also cover inhalants, chemicals, drugs, fungi, yeasts, viruses, hormones, terpenes, air-pollutants, insects, and contact dermatitis.

Registration fee of $125 also covers one dinner and two luncheons. To register for the course send name, address, and check (payable to Provocative Allergy Course) to: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609. Room reservations should be made directly with hotel.

Postgraduate Course in Pediatrics. The University of Texas Medical Branch, March 15–16, 1973. Course will emphasize "Problems of Office Pediatrics," with guest lecturers Victor C. Vaughan, III, MD and John B. Reinhart, MD.

Program is acceptable for 12 *prescribed* hours by American Academy of Family Physicians; registration fee: $75. Further info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Texas Medical Branch, Galveston, Tex. 77550.

Pediatric Symposium. The Marshfield Clinic Foundation in Marshfield is sponsoring a Pediatric Symposium November 11. Guest speaker will be Dr. Heinz F. Eichenwald, professor and chairman of the Department of Pediatrics, University of Texas, Southwestern Medical School, Dallas, Tex.

REGISTRATION FORM

1972–1973 In-Depth Teaching Programs

Coordinated by the State Medical Society of Wisconsin

PLEASE CHECK the programs you plan to attend ($30 for *all four*; $8 for *each program less than four*. Enclose your check for proper amount payable to:

Charitable, Educational and Scientific Foundation
P. O. Box 1109, Madison, Wisconsin 53701

PLEASE CHECK SESSIONS YOU WISH TO ATTEND

St. Mary's Hospital

☐ Wed., Nov. 15, 1972
☐ Thurs., Dec. 14, 1972
☐ Wed., Jan. 17, 1973

Madison General Hospital

☐ Thurs., Feb. 15, 1973
Registration at 9:30 a.m. on all dates

You will be assigned the topic you have selected on one of the above dates. Your schedule of topics and dates will be sent to you as soon as it has been completed.

MORNING WORKSHOP TOPICS

Write "1–2–3–4" in Order of Your Preference

_____ Respiratory Emergencies
_____ Dr. Blue, Blue-cart, Code 99, or whatever you call it
_____ Clinical Cardiology
_____ Rheumatology
_____ Renal Disease
_____ Quality of Care—Appraisal Workshop
_____ Proctological Problems
_____ Pathology for the Practitioner
_____ Urological Problems

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(area code) (number)

1972–1973 In-Depth Teaching Programs

The forthcoming series of In-Depth Teaching Programs

THE EFFECTS OF MULTIPLE INJURIES

are provided by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, in cooperation with the University of Wisconsin Medical School, St. Marys Hospital Medical Center, and Madison General Hospital.

Objectives of this year's lecture series is to explore in depth the systemic effects of multiple and massive injuries. Course is designed for physicians maintaining primary care responsibility for patients.

ST MARYS HOSPITAL

Wednesday, Nov. 15, 1972
Thursday, Dec. 14, 1972
Wednesday, Jan. 17, 1973

MADISON GENERAL HOSPITAL

Thursday, Feb. 15, 1973
Registration at 9:30 a.m.

Morning Workshop Topics

*Respiratory Emergencies
*Dr. Blue, Blue-cart, Code 99, or whatever you call it
*Clinical Cardiology
*Rheumatology
*Renal Disease
*Quality of Care—Appraisal Workshop
*Proctological Problems
*Pathology for the Practitioner
*Urological Problems

Afternoon Lectures

Nov. 15: *Hemodynamics and Nutrition,* Joseph A. Moylan, MD, Asst Prof of Surgery, UW Medical School; *The Internist's Concerns,* Marvin L. Birnbaum, MD, Asst Prof of Medicine and Physiology, UW MS

Dec. 14: *The Emergency Room Physician's Concerns,* Joseph A. Moylan, MD; *The Cardiologist's Concerns,* Neville Bittar, MD, Assoc Prof of Medicine, UW MS

Jan. 17: *The Anesthesiologist's Concerns* S. Craighead Alexander, MD, Prof and Chrm, Dept of Anesthesiology, UW MS; *The Obstetrician's Concerns,* David A. Horwitz, MD, Asst Prof of GYN OB, UW MS

Feb. 15: *The Psychiatrist's Concerns for the Patient and Family,* John H. Greist, MD, Prof of Psychiatry, UW MS; *The Physiatrist's Concerns,* speaker to be announced

Fee for all four programs: $30; each program less than four: $8. Checks payable to: CES Foundation.

Advance registration should be made with David C. Reynolds, Director of Scientific Services, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. (See form at left)

Special Family Practice Conferences

SCHEDULED IN 1972–1973 AT

Neenah • Wausau • Eau Claire

The University of Wisconsin Center for Health Sciences and the Department of Postgraduate Medical Education of UW Extension announce a series of one-day "In Depth" instructional meetings for Family Physicians in Neenah, Wausau, and Eau Claire in October–November 1972 and April–May 1973.

Each day will cover two basic areas of medical practice, with instruction of a "workshop" nature in the morning and a two-hour lecture program following lunch. Morning instruction will be provided by local specialists, and UW faculty members will be used as resource personnel.

A complete series of four conferences will provide 16 hours of *prescribed* AAFP credit. Cost is $10 per individual meeting, or $35 for the series.

Cosponsors are the State Medical Society's Charitable, Educational and Scientific Foundation and the Wisconsin Academy of Family Physicians.

NEENAH Conferences—Theda Clark Memorial Hospital

Oct. 11 (Wed.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 1 (Wed.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 11 (Wed.): Cardiology and Neurosurgery
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *Manucher Javid, MD,* Professor of Surgery

May 9 (Wed.): Nephrology and Urology
UW FACULTY: *Frank D. Gutmann, MD,* Assistant Professor of Medicine; *G. H. Malek, MD,* Assistant Professor of Surgery

WAUSAU Conferences—Wausau Hospital North

Oct. 12 (Thur.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 2 (Thur.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 12 (Thur.): Cardiology and Neurosurgery
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *Manucher Javid, MD,* Professor of Surgery

May 10 (Thur.): Ophthalmology and Otolaryngology
UW FACULTY: *George Bresnick, MD,* Assistant Professor of Ophthalmology; *James H. Brandenburg, MD,* Professor of Surgery (ENT)

EAU CLAIRE Conferences—Sacred Heart Hospital (October and November); Luther Hospital (April and May)

Oct. 18 (Wed.): Orthopedics and Diabetes
UW FACULTY: *Andrew A. McBeath, MD,* Associate Professor of Surgery; *Edgar S. Gordon, MD,* Professor of Medicine

Nov. 8 (Wed.): Obstetrics–Gynecology and Psychiatry
UW FACULTY: *C. Weir Horswill, MD,* Assistant Professor of Obstetrics–Gynecology; *Benjamin Glover, MD,* Associate Professor of Psychiatry

Apr. 18 (Wed.): Cardiology and Pediatrics
UW FACULTY: *Ernest W. Reynolds, MD,* Professor of Medicine; *William E. Segar, MD,* Professor of Pediatrics

May 16 (Wed.): Dermatology and Otolaryngology
UW FACULTY: *Derek J. Cripps, MD,* Associate Professor of Dermatology; *James H. Brandenburg, MD,* Professor of Surgery (ENT)

Those wishing to register mail check (payable to CES Foundation) of $35 for series or $10 per individual conference to Roy T. Ragatz, Department of Postgraduate Medical Education, 610 Walnut Street, Madison, Wis. 53706. CLEARLY INDICATE WHAT SERIES OR INDIVIDUAL CONFERENCE YOUR CHECK COVERS.

CONTRIBUTIONS—CES FOUNDATION

August 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1972:

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

PRESIDENT'S PAGE

The Governor's Health Planning and Policy Task Force

WITHIN THE NEXT SEVERAL WEEKS the Task Force will be completing its assignment and will submit final reports and recommendations to the Governor. These reports will cover a wide range of subjects relating to comprehensive health planning for the State of Wisconsin.

The State Medical Society's representative on the Task Force has actively participated in the lengthy and exhaustive meetings during the past year. The State Medical Society has attempted to keep pace with developments as some of the preliminary reports unfolded. Recommendations by our Society relating to health coverage for the uninsurable and the unemployed have been favorably received by the Task Force.

I would urge every physician in the state to study the various reports and recommendations as they are released and to thoroughly discuss them at the county level. Each member of our Society should be well informed on such vital matters as comprehensive health planning legislation; the 45-member Health Policy and Program Council—to be appointed by the Governor; a three-man Health Services Commission appointed by the Governor; quality health care review; certificate of need, and the many other subjects related to health care. Physicians will surely await with interest the report of the chiropractic study committee.

The State Medical Society's Commission on Public Policy, the Executive Committee of the Council, and the Council have devoted many hours of discussion on reports stemming from the Task Force. Many preliminary reports on a wide range of subjects have been released to the press simply to secure public reaction. Much of the discussion within the Task Force has focused on more and more government control of comprehensive health planning to include the full range of physical, mental, and environmental health needs and these services, plus facilities and manpower required to meet those needs. That is a mighty big order. For the past century and beyond these needs have been primarily met by private physicians and hospitals with little or no governmental help—or control.

Within the past several weeks your President has experienced the splendid, faultless medical–hospital care available to the citizens of Wisconsin. I underwent open heart surgery in early September and had an aortic valve replacement to correct an aortic stenosis. The extensive preoperative workup, the surgical team, and the well trained, around-the-clock postoperative monitoring, was a moving and amazing thing to undergo as a patient. I am thoroughly convinced that the private practice of medicine as it now functions is the very finest available anywhere on this green earth. Surely there are parts of this total operation that need attention and correction. I do not believe, however, that the entire health structure as we now know it must be brought under a state-operated, politically controlled commission. I do not believe that the citizens of this state would want that sort of a state-operated health system.

Robert F. Purtell, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Transition—third of a series

SINCE WE HAVE no assurance that our present knowledge will be valid or even useful in the very near future, we must address ourselves seriously to the implications of this possibility. Even though such radical changes offer the citizen a wider range of choices, there are problems inherent in this very fact as Toffler *(Future Shock)* and others have pointed out. One real flaw in all this is that our traditional values may not provide a basis on which to assess the choices becoming available to us.

This conflict has been called to your attention before in this space. It amounts to our current curious dilemma about the scientific method we know so well as it runs head onto political reality. The password is "human need" and "how do we know it won't help" and even more directly "I've seen it work." These attitudes, which all decry as antiscientific, are becoming valid in the health service and delivery areas. Chiropractic is but one small piece of this puzzle; and if that were all, I suppose we could withstand and even outnumber these pretenders. What we seem not sure about, and not able to recognize let alone withstand, are the thrusts against our systems of thinking. True, these demands are directly contradictory to our traditional values—that some training be undertaken before treatment is offered, and that such training and experience is a necessary part of all health planning. Examples: chiropractors are put on health delivery boards and only a few seem to notice anything unusual about that; a high level medical practice board is formed in Milwaukee without one physician member, and protests by the Medical Society bring an offer of one space on a subcommittee; a social worker in private practice of psychotherapy seems offended when I refuse to rent him my office to practice what I've spent ten times the training time to learn; the autonomy of the physician we have learned so well, and loved so well is eroded by popularity contests to become members of credentials committees, peer review groups, and the like; and worst of all, in my specialty at least, there is a growing feeling that American Boards are not only unnecessary but that such a judgment by peers is irrelevant. Which way will it go? I don't know, of course, but these and many other sudden and severe shifts of emphasis are occurring and may

change the entire face of medicine. Can we cope with these changes, or even know how to steer our boat on the basis of the cold blue light of science that we learned in medical school, and the hard core puritan discipline we were taught to respect? None of the examples above have anything to do with science or with discipline. So how can our training in these areas help? The examples given are real, pertinent, and local. At the national level we are now running into such problems as genetic engineering, human hibernation, when does death really occur for transplant purposes, surrogate mothers, artificial intelligence, parthenogenesis, and the like.

From all this comes the need to reassess our most traditional values: privacy, the family, human prerogatives in medicine, all aspects of procreation, the state's "right" to hospitalize a person psychiatrically, for his and his society's "good."

The problems themselves are bad enough but there is a further overriding problem, and that is that these fulsome complications are often so contradictory and frequently insolvable as to produce the most serious stress to our self-identity. How do we decide these things, and what do we think of ourselves when we decide one way and thus deny the crying arguments for the other system? Or worse, what if we cannot decide and yet believe that as physicians we should decide, and are failures if we do not? The term identity crisis is grossly overworked not only in psychiatry but also in our complex world today. Those of us who are used to direct, clear solutions, or at least used to direct and clear methods to find some solution to human ills, find we cannot so easily solve these larger issues,—*and* think differently about ourselves when we cannot do so. But we cannot take it too personally, for every organization seems pressed to define who they are and what they do. Simplistic answers are really not valid for the solution of the problems inherent in the complex interaction between modern social structure and the quality of life itself. Why this should be so I cannot know. Perhaps sheer mass of persons, coupled with vastly increased mechanical facilities, increase the pressures by geometrical proportions. What ever the reasons, the emotional crises are upon us, if we choose to look.—RH

Reye's Syndrome

THE REPORT OF Sen and Subapodok, appearing elsewhere in this issue, adds two more cases of Reye's syndrome to those already reported. This uncommon condition (or group of conditions with something of a "final common pathway," as some might maintain) was first described by Reye et al in 1963 in a paper entitled, "Encephalopathy and Fatty Degeneration of the Viscera; A Disease Entity in Childhood." Reye and his colleagues reported data concerning 21 children, ranging in age from 5 months to 8½ years, whose outstanding clinical features were disturbed consciousness, fever, convulsions, vomiting, and hyperpnea. Hypoglycemia and low cerebrospinal fluid glucose and elevated levels of serum glutamic-oxaloacetic transaminase and serum glutamic-pyruvic transminase were also described. Mortality in the cases described by Reye et al was high: 17 out of 21 of the patients died. At autopsy, severe fatty degeneration of the liver, kidneys, myocardium, and acinar cells of the pancreas was revealed. There was no necrosis. Changes in the central nervous system were nonspecific: cerebral edema was the most prominent feature; neuronal changes were variable and not characteristic of a particular lesion. There were no other anatomic changes of importance. Reports subsequent to those of Reye et al have mostly concerned small numbers of cases

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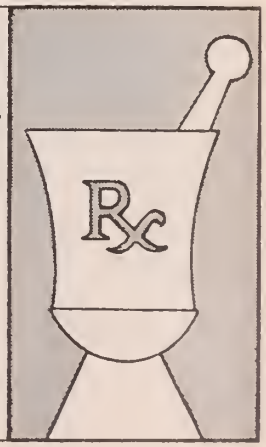

similar to those originally described. (However, see comments below on the largest number of apparently related cases from Thailand.)

A crucial point in the study of all disease processes is the search for a cause or causes. In this respect, Reye's syndrome has proved difficult. Reye himself mentioned that the "vomiting sickness" of Jamaica bore certain resemblances to the condition he described. Other authors added other disease processes including mushroom poisoning, the White Liver Disease, varicella, salicylism, and numbers of others. In particular, some authors have been insistent on a possible virus causation. None of these suggestions, however, has proved tenable. Ammonia intoxication of the brain has been suggested as the cause of the encephalopathy, with the thought that the assumed antecedent liver disease caused the ammonia intoxication. However, this assumption begs the issue of what caused the disease of the liver and other abdominal and thoracic viscera.

An intriguing possibility concerning the cause of Reye's syndrome has been developed by several authors beginning with Becroft in 1966, and continuing with epidemiologic and some experimental work. This suggestion has been that Reye's syndrome is caused by the toxic effect of aflatoxins (particularly aflatoxin B_1) on the liver, kidneys, brain, and other organs. The aflatoxins, produced by certain fungi (some strains of *Aspergillus flavus*) that commonly grow on grain and other food products, have been proved to be causative of a number of outbreaks of disease affecting domestic animals. Experimental studies of Bourgeois and others in Macaque monkeys have shown effects of aflatoxin B_1 which strikingly parallel those of clinical cases of Reye's syndrome.

An interesting demographic and geographic aspect to cases of Reye's syndrome has been the number of cases reported from Thailand. The largest number of cases that we know of, for example, is that of Olson et al, who reported 67 cases of "encephalopathy and fatty degeneration of the viscera" seen in one hospital in northeastern Thailand in 1969. These cases appear to represent instances of Reye's syndrome. Aflatoxin B_1 is commonly found in Thailand: the experimental work of Bourgeois et al, referred to above, was based in Thailand, and used aflatoxin derived from rice used as food by a family in which a fatal case of Reye's syndrome had occurred. On balance, we believe the aflatoxin theory is the most satisfactory one developed to date, though obviously more clinical work and basic research are needed to establish the cause with clarity and completeness.

One fact about Reye's syndrome requires some separate explanation—the occurrence of the syndrome only in children. It is assumed by virtually all investigators into the problem, whatever their concept about the cause of the syndrome, that the explanation lies in the greater susceptibility of children than of adults to infectious, toxic and other stimuli. There are parallels to this assumption, though there is imprecision and incompleteness in this explanation of the age incidence.

Therapy of cases of Reye's syndrome has been unsatisfactory. The rapidity of evolution of the cases has been one of the reasons for the difficulty, and the lack of precise knowledge of the cause the other main disturbing factor. Reye and his colleagues said they gained the impression that the continuous infusion of glucose and the concomitant use of a corticosteroid improved the chances of survival. In general, however, antibiotics, corticosteroids, glucose infusions, and other methods have had very uneven results.

Characterization of Reye's syndrome and search for its cause and mechanisms offer a look into multisystem disease that may give data on many diseases and processes apart from the syndrome itself. Similarly, search for treatment for Reye's syndrome may both enable the clinician to save more of these patients and to apply therapeutic information thus gained to other diseases of wider import and higher incidence.—CHESLEY P. ERWIN, MD, Medical College of Wisconsin, Milwaukee

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A Brief Clinical Experience in a Developing Nation

EDWARD H. KOLNER, MD and MARY S. KOLNER, BS
Madison, Wisconsin

EACH YEAR MANY HUNDREDS of physicians and technically trained individuals serve for brief periods as volunteers in developing areas throughout the world. Our own experience was richly rewarding in personal satisfaction despite its frustrations. We felt that an objective quantification, however peculiar to the area and the circumstances, might prove of some value to organizations engaged in providing support services as well as being useful to potential volunteers in preparing them for what they might encounter.

Setting

Our *dispensario* consisted of a small outpatient facility in a town of 5000 population in the Dominican Republic. In the same town there is a government-operated maternity hospital staffed by one or two full-time physicians, where uncomplicated obstetrics is performed. There are no other doctors serving the surrounding area of some 40,000 inhabitants. Three unlicensed "dentists" practice in the town. The next nearest medical care is 20 miles away, where there are 18 physicians and a general hospital. Intercity transportation is usually by *publicos,* taxis operating at a fare of 50 cents per passenger.

The *dispensario* staff consisted of a registration clerk, a family practitioner, and two assistants, one of whom was bilingual and functioned as a translator. Clinic hours were 9 to 12 AM and 2 to 5 PM. Laboratory equipment was virtually non-existent, but we were able to rent a microscope. There were no centrifuge, stains, cover-slips, hemaglobinometer, or x-ray machine. All the examining gloves were a useless size 6.5. There were no minor surgery instruments or plaster. Running water was unavailable during the working day.

The medication supply was generally adequate for our needs, with a good supply of oral antibiotics. There was an oversupply of proprietary items such as mouthwash, cold remedies, nasal sprays, and first aid creams. Necessary medications unavailable in our *dispensario,* such as scabicides, could usually be purchased by the patients at the pharmacy in the town.

Clinical Experience

In 15 clinic days, 912 patients were seen, for an average of 60 per day. The breakdown by gender and age is shown in Figure 1. In Figure 2 are displayed categories of conditions seen in descending order of frequency; two or more complaints per patient were not uncommon.

Comment

The variety of problems encountered are those of any general practice, but different in proportion. Additionally, of course, there are conditions peculiar to the tropic and to the local environment.

Reprint requests to: Edward H. Kolner, MD, 5714 Odana Road, Madison, Wis. 53711.
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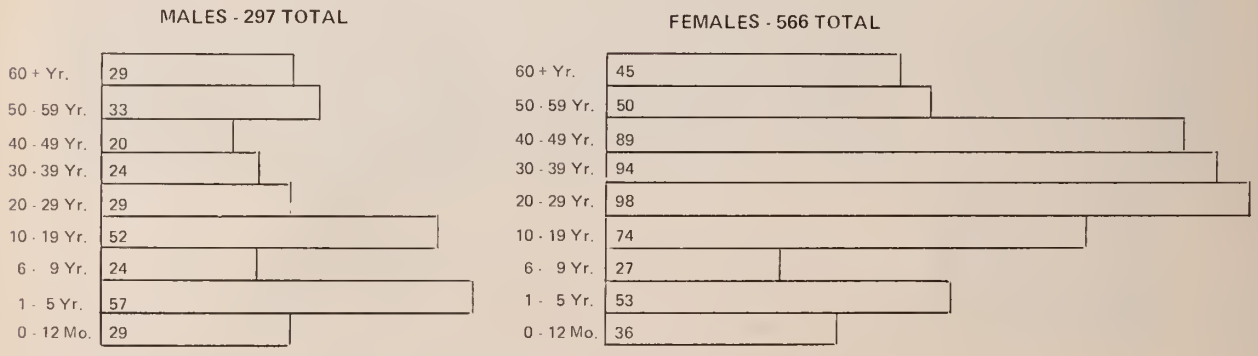

Figure 1—Distribution of patients by sex and age.

Gastrointestinal

Parasitism led the gastrointestinal (GI) complaints. Patients generally had passed some of the ascarides of which they complained, and the children were almost universally infested. The second most common parasite was Trichuris (whipworm). We had no medication to dispense for this infection; the literature suggests that the morbidity with this parasite is low, hence we did not prescribe for it. Hookworm infection is known to be universal in areas of poor sanitation in the tropics where the populace is barefoot much of the time; however, without laboratory equipment we were unable to diagnose this disease.

Much chronic pain and distress of the GI tract was a common complaint, and many cases of acute gastroenteritis were seen. Where the water supply is not filtered, chlorinated, or boiled, where food is easily contaminated by flies and unwashed hands, and where refrigeration is a luxury, much gastroenteritis is to be expected. Somehow the need to boil milk before drinking it has been thoroughly indoctrinated into the people. Of course, they often pour the boiled milk over contaminated ice before drinking it.

The diet of the people is primarily carbohydrate: rice, plantain, manioc, and potatoes are staples. There is an excellent variety of fresh fruits and vegetables. Probably the diet contributes to the chronic complaints of gassiness and abdominal pains among the middle aged and elderly. Meat is expensive, and a physician told us that only 10 percent of the population eat meat daily, while another 30 percent might eat eggs. Fish is seldom available away from the coast because of lack of refrigeration.

Malnutrition severe enough to require hospitalization was encountered in 10 infants. These included both marasmus and kwashiorkor cases. All were in children under 3 years of age. Usually the initiating episode in the malnutrition was a gastroenteritis that never cleared.

Respiratory

Respiratory infections were very common. While the daytime hours are very warm, the nights are quite cool and damp. We saw no homes with any form of heating, and we suspect that little money could be found to spend on warm blankets.

Dermatological

Skin problems were nearly all a result of uncleanliness and probably could have been reduced by twice weekly bathing with hot water and soap, a seeming impossibility unless community effort is mobilized.

Orthopedic

Musculo-skeletal complaints were common and we thought they were related to the malnutrition, chronic anemia, cold, damp nights, and the physically hard life of people who earn their livelihood as laborers in a land where machinery and tools are scarce. A nearly ubiquitous complaint which could be elicited among the adults as well as among some of the teenagers was *dolor in todo cuerpo* (pain in the entire body). The

CONDITIONS SEEN

Gastrointestinal		
Parasitism		149
Pain and distress		115
Gastroenteritis		68
Malnutrition		10
Miscellaneous		19
	TOTAL	351
Respiratory		
Infections		212
Inhalant allergy and asthma		34
Other		7
	TOTAL	253
Skin		
Infections		49
Scabies		22
Tinea		11
I and Ds and followups		11
Other		26
	TOTAL	119
Musculoskeletal		
Todo cuerpo		57
Backache		27
Arthritis and joint pains		27
	TOTAL	111
Obstetric–Gynecologic		
Gynecology		65
Pregnancy		35
Breast		5
	TOTAL	105
Neurologic–Psychiatric		
Headache		38
Anxiety and Tension		35
Sleeplessness		14
Vertigo		9
Convulsive disorders		4
Parkinsonism		2
	TOTAL	102
Cardiovascular		
Hypertension		28
Chest pain		9
Arteriosclerotic		7
Other		5
	TOTAL	49
Dental	TOTAL	31
Genitourinary		
UTI		14
Other		11
	TOTAL	25
Ear Problems	TOTAL	21
Eye Problems	TOTAL	15
Trauma	TOTAL	5
Varicose Veins	TOTAL	5
Large Hernias	TOTAL	4
Diabetes	TOTAL	4
Nose and sinuses (nonallergic)	TOTAL	3
Reassurance and miscellaneous	TOTAL	17
GRAND TOTAL		1230

Figure 2

patient would begin by putting his hands on his ankles, then knees, hips, abdomen, chest, back, shoulders, neck, and temples. We learned to call this pantomime "the litany pain."

Obstetric–Gynecologic

Although we had no equipment for obstetric–gynecologic examination, many of the patients were pregnant and many had various pelvic or vaginal problems. It was possible to refer these patients to the Maternity Hospital which had active outpatient clinic, including family *planificacion* clinics, a desperately needed service.

Neurologic–Psychiatric

Nervous and psychiatric complaints probably received undue emphasis as a result of chronic anemia and malnutrition. Perhaps many of these complaints could have been prevented or resolved by eliminating the physical conditions that underlay them.

Dental

The dental health of children and adults was atrocious. Factors responsible include malnutrition, over liberal use of sugar, and neglect of early dental caries. Secondary to the dental problems there are numerous head, neck, and face complaints, and digestive disturbances.

Discussion

The health problems of the developing nations cannot be solved by the techniques of the doctor–patient relationship alone. The manpower simply does not exist nor will it exist in the future. The only effective way is the way of public health: education, sanitation, immunization, and mass screening. Massive effort will be needed, but the rewards will be incalculable.

So many ideas come to mind, even to the short-term volunteer, that seem worthy of exploration: mandatory daily school time devoted to health, hygiene, and sanitation instruction (easy to initiate in countries with very strong central governments); radio and TV classes daily to the adults (radio is nearly universal in some areas and TV is not uncommon despite great poverty); development and improvement of water and sewerage systems; mobile immunization and case-finding teams; training of public health technicians, sanitarians, medical and dental assistants, nurses, and technicians; community bath houses; lay education for practical child nutrition (e.g., could a family keep a goat for milk when refrigeration is not available?).

Although the time was short, our efforts were sincerely appreciated by the people. There is a great need for short-term and long-term volunteers in many lands. Organizations such as the Direct Relief Foundation, P. O. Box 1319, Santa Barbara, Calif. 93102, and the Catholic Medical Mission Board, 10 West 17th Street, New York, N.Y. 10011, coordinate available positions with volunteers, and are pleased to receive inquiries. The richness of our experience led us to say, as have so many others, "We got more than we gave." □

Interested in a Working Vacation Abroad?

Some of the major organizations sponsoring volunteer physicians abroad are listed here for the benefit of Wisconsin physicians wishing to spend vacations in other countries where their medical knowledge and help are needed. Interested physicians should contact directly the sponsoring organization of their choice for further information.

- **Volunteer Physicians for Viet Nam,** 535 North Dearborn St., Chicago, Ill. 60610.
- **Project HOPE,** The People-to-People Health Foundation, Inc., 2233 Wisconsin Ave., Washington, D.C. 20007.
- **AmDoc, Inc.,** 27 E. Cannon Perdido St., Santa Barbara, Calif. 93101.
- **FOCUS, Inc.** (Ophthalmologists), 1431 Ashland Ave., River Forest, Ill. 60305.
- **Project Concern, Inc.,** P.O. Box 2468, San Diego, Calif. 92112.
- **Medical Assistance Programs, Inc.,** Box 50, Wheaton, Ill. 60187.
- **Catholic Medical Mission Board,** 10 W. 17th St., New York, 10011.
- **Christian Medical Council for Overseas Work,** National Council of the Churches of Christ in the USA, 475 Riverside Dr., New York 10027.
- **World Brotherhood Exchange,** Lutheran Council in the USA, 315 Park Ave. S., New York 10010.
- **Operation Crossroads Africa, Inc.,** 150 Fifth Ave., New York 10011.
- **MEDICO,** Orthopaedics Overseas Division, 2007 Eve St., NW, Washington, D.C. 20006.
- **Holidays for Humanity, Inc.,** 3700 Bellemeade Ave., Suite 105, Evansville, Ind. 47715.
- **Direct Relief Foundation,** P.O. Box 1319, Santa Barbara, Calif. 93102.

Women in Nineteenth Century Wisconsin Medicine

DENNIS H. PHILLIPS
Madison, Wisconsin

MEDICAL HISTORY FEATURE

Award-winning paper in the first essay contest of the State Medical Society of Wisconsin's Charitable, Educational and Scientific Foundation to foster interest in documenting Wisconsin's medical history.

Dedicated to Jebby who proposed the idea.

When Laura J. Ross, MD, dared to be the first woman physician to apply for membership in the Milwaukee City Medical Society early in 1869, most of the men in the organization were astonished. Many of the distinguished doctors were convinced that the admission of a 'woman doctor' would serve as a death-blow to the society. The men were in a quandry because Doctor Ross, who had come to Milwaukee in 1857, was one of the leading physicians in the city. Her character, credentials, and competence were all impeccable. Hoping to avoid the onus of denying her admission strictly on the basis of sex, the men delayed action on her application. They expected her to respond in a 'ladylike' manner and avoid a nasty public confrontation by withdrawing her name from consideration. Totally misjudging the woman's determination, they were forced to bow quietly though reluctantly to the principle of equality. On January 21, 1869, Doctor Ross was elected the first woman member of the Milwaukee Medical Society.[1]

The victory of Doctor Ross in Wisconsin followed a pioneering pattern set by an extraordinary corps of nineteenth century women physicians. These women not only fought to acquire technical competence equal to that of men but, once that battle was won, they struggled to overcome professional and public prejudice against women doctors. When in 1849 Elizabeth Blackwell became the first woman in America to earn a medical diploma, she faced stringent opposition from both sexes for her 'unladylike' ambition. A few years later her sister, Emily, was refused admission by more than ten medical schools, including the Geneva, New York institution which had graduated her sister but was "not prepared to consider the case . . . a precedent."[2]

When Harriet K. Hunt, who had successfully practiced medicine for fifteen years without a diploma, applied to take medical courses at Harvard, her efforts were inadvertently undermined by the prior admission of a black man. The white male students felt that they could not also accept a woman because "their cup of humiliation" was already full. Dean Oliver Wendell Holmes favored Hunt's

Mr. Phillips was a graduate student in history at the University of Wisconsin. He now is associated with the History Department of Macquarie University, North Ryde, N.S.W. 2113, Australia.

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[1]F. M. Sperry, *A Group of Distinguished Physicians and Surgeons of Milwaukee* (Chicago: J. H. Beers & Co., 1904), pp. 11–12; L. F. Frank, *The Medical History of Milwaukee, 1834–1914* (Milwaukee: Germania Publishing Co., 1915), p. 119.

[2]See Lucia Gilbert Runkle's essay, "The Doctors Blackwell," Chapter VI in Harriet Beecher Stowe *et al., Our Famous Women: Comprising the Lives and Deeds of American Women* (Hartford: A. D. Worthington & Co., 1884), pp. 134–151; The Rev. H. B. Elliot in "Women as Physician" in James Parton, *et al., Eminent Women of the Age; Being Narratives of the Lives and Deeds of the Most Prominent Women of the Present Generation* (Hartford: S. M. Betts & Co., 1868), p. 524 states that when Elizabeth Blackwell arrived in Geneva, "so violent . . . was the opposition of her own sex, that during those two years no lady in Geneva would make her acquaintance; common civilities, even at the table, were denied her, and in the street she was deemed unworthy of recognition." Emily entered Rush Medical College at Chicago in 1852. When that school was censured by the State Medical Society for admitting her she completed her studies at Cleveland. On the fascinating career of the Blackwell sisters see Dorothy C. Wilson, *Lone Woman: The Story of Elizabeth Blackwell The First Woman Doctor* (Boston: Little, Brown, 1970) and Ann McFerran, *Elizabeth Blackwell, First Woman Doctor* (New York: Grosset & Dunlap, 1966). The latter is a children's book.

[3]Annie N. Meyer, ed., *Woman's Work in America* (New York: Henry Holt, 1891), p. 148; Robert F. Karolevitz, *Doctors of the Old West: A Pictoral History of Medicine on the Frontier* (Seattle: Superior Publishing Co., 1967), p. 157; Thomas Woody, *A History of Women's Education in the United States* (2 vols., New York: Octagon, 1966), II:345–347.

admission but irate students filed protesting resolutions complaining that "no woman of true delicacy would be willing in the presence of men to listen to the discussions of the subjects that necessarily come under consideration of the student of medicine." Rather than face a student revolt the faculty bowed to the protest and refused to admit Harriet Hunt.[3]

Laura Ross also wanted to enter Harvard but she realized that "the time was not ripe for such an innovation." She followed a course of independent study with guided readings recommended by sympathetic Harvard professors. She then entered the Woman's Medical College at Philadelphia, the first permanent institution of its kind, and received her medical diploma in 1856. As she overcame local prejudice, her practice in Milwaukee grew rapidly. She became a consulting physician for several hospitals, the Orphan's Asylum, St. John's Home for Aged Women, and the Industrial School for Girls. She was one of the first to expose the wretched conditions in the poorhouse and county jail. She was a member of the Women's Christian Temperance Union, the Humane Society, and the State Academy of Arts, Science and Letters.

Doctor Ross was also a political activist. Drawing inspiration from childhood heroes like Wendell Phillips, William Lloyd Garrison, Margaret Fuller, and Lydia Child, she became involved in many Wisconsin reform movements. She helped organize the "Woman's Exchange," formed in the interest of education, aid, and safety for women in industry. It was largely through her efforts that the first woman's suffrage convention held in Wisconsin met in Milwaukee in 1869. She bore the expense and made most of the arrangements for that meeting and one that followed in the Senate Chamber of the State Capitol in Madison. Susan B. Anthony, Elizabeth Cady Stanton, Mary A. Livermore, and other nationally known representatives of the movement were present at her request.[4]

In 1869 Doctor Ross married Erastus B. Wolcott (1804–1880), a prominent Milwaukee physician and surgeon-general of Wisconsin.[5] After his death eleven years later she made one of several trips to Europe to continue her medical studies. She attended Cambridge University in England and studied in the surgical wards of the *Maison de Santé* in Paris where she attracted the attention of the Empress Eugenie who intervened personally to secure advantages for the industrious Wisconsin woman physician. By the end of the nineteenth century there were few Wisconsin doctors of either sex who could rival the reputation of Milwaukee's Dr. Laura Ross Wolcott.

Dr. Margaret Caldwell of Waukesha was one of the few. Born in a log cabin in 1845, daughter of parents who were among the first settlers of Pewaukee, Margaret Caldwell began teaching school at the age of fifteen. Attracted to medicine, she went to Chicago and earned a medical degree at the Woman's Medical College. In 1871, while working in a poor section of the city, she lost all her possessions when forced to flee before the Chicago fire. A giant of a woman in her prime, almost six feet tall and weighing over 200 pounds, she came to Waukesha in 1878 and opened a sanitarium for women while battling the disdain of the male doctors in the area. She eventually overcame "a strong and active antagonism among her male colleagues" and was elected President of the Waukesha County Medical Society.[6]

Doctor Caldwell had the presence of mind to take advantage of a good thing when she arrived in Waukesha. The city had already become known as "the Saratoga of the West" as a result of the alleged medicinal properties of Bethesda Spring. Margaret Caldwell became custodian and attending physician at the Bethesda Spring baths. The baths attracted numerous patients, many from the deep South and many who enjoyed great wealth. The income derived from her position as physician there enabled Doctor Caldwell to travel abroad frequently. In the 1890s she represented Wisconsin at an international medical convention in Rome.

Unlike Laura Ross, Doctor Caldwell avoided political issues, preferring instead to devote herself entirely to her practice and medical research. Throughout her professional life she contributed frequently to medical journals. At the time of her death in 1938 at the age of 92 she was considered the dean of women physicians in the state.[7]

Dr. Bertha V. Thomson of Necedah was one of Doctor Caldwell's distinguished contemporaries. Doctor Thomson, who grew up close to the Menominee and Potawatomi Indians, possessed an almost mystic attraction to medicine from early childhood. As an elderly woman in the 1930s, she wrote:

> When I was but a small child, I could rub away headaches . . . when anyone was sick I was a transformed being, ready to give up everything to help. My

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[4] Sperry, *Physicians and Surgeons of Milwaukee,* pp. 7–9; *The Milwaukee Sentinel,* Feb. 24, 25, 1869; Theodora W. Youmans, "How Wisconsin Women Won the Ballot," *Wisconsin Magazine of History,* V (1921–1922), 9; *Biographies of Physicians and Surgeons* (Chicago: J. H. Beers, 1904), p. 249; Walter Harris, *The Story of Medicine in Wisconsin* (El Paso: Walter Harris, 1958), p. 48; Frank, *Medical History of Milwaukee,* p. 35.

[5] Sperry, *Physicians and Surgeons of Milwaukee,* pp. 1–7.

[6] *Waukesha Daily Freeman,* June 6, 1878 and May 5, 1938.

[7] Many of Dr. Caldwell's letters, articles and clippings are available in the Wisconsin State Historical Society, Manuscript Division, *Records of the Wisconsin State Medical Society, Woman's Auxiliary Papers* (hereafter cited: *WSMS, WAP*), "History of Waukesha County Physicians, 1838–1941." See also the *Milwaukee Journal,* May 20, 1934 and May 4, 1938; *Waukesha Daily Freeman,* May 4 and 5, 1938; For examples of three of Dr. Caldwell's scientific articles see "Pelvic Cellulitis," *Transactions of the State Medical Society of Wisconsin, 1886,* pp. 127–132; "Spinal Irritation; or, Rachialgia," *Ibid., 1887,* pp. 177–182; and "How Shall We Treat Abortions?", *Ibid., 1898,* pp. 384–388; letter to the author from David Keyser, great nephew of Dr. Caldwell, Milwaukee (May 13, 1972).

mother was a healing medium and did a great deal of that work when she was carrying me. I have often wondered if this had anything to do with this desire of mine.[8]

Like so many other Wisconsin women physicians, Bertha Thomson received her formal medical training at Chicago. For a time she was in charge of nurses at the Brainerd, Minnesota Railroad Hospital, but in 1895 she came to Oshkosh as an assistant to Dr. C. W. Oviatt, one of the principal surgeons in the area. She attended many of his women patients. At the turn of the century she served as city physician, the first woman in the United States to hold such an official position. At the request of Dr. W. A. Gordon, superintendent of the Northern Hospital for the Insane, she served three and one-half years as the first woman on the staff coequal with male physicians. When she returned to private practice in Oshkosh, she was elected full time health officer by the city commission in 1919.[9]

Dr. Maybelle M. Park was another Wisconsin woman physician who pioneered by breaking the male grip on official city and county health posts. Born January 7, 1871, at Dodge's Corners, she attended Carroll College, the University of Wisconsin, and the Woman's Medical College of Pennsylvania (MD, 1894). Square jawed and strikingly attractive, she became the first woman in the state to serve as a county health physician when she was appointed to the post in Waukesha County at the age of 27 in 1898. The salary was $250 annually. She served two terms in that capacity, then became an assistant physician for ten years at the Waukesha Spring Sanitarium. Like Doctor Ross in Milwaukee, she maintained active political interests. She read a paper entitled, "Does the Professional Woman Need the Ballot?," at a suffragist meeting in Madison in 1897. As county health physician she pressed energetically for prison reform, demanding a hospital room in the county jail.[10]

Doctors Ross, Caldwell, Thomson and Park, pioneers in their own right, owed much to the women who practiced medicine in Wisconsin during the first half of the nineteenth century. In 1814 a British captain, J. G. Anderson, stationed at Fort McKay in Prairie du Chien recorded in his diary the burial of a woman named Marie, "an excellent old doctress" of the Sioux nation, who had long served "amongst the White people." In 1833 "Aunt Mary Ann" Labuche, a half-breed Indian woman died at Prairie du Chien. For many years she had been "a midwife and the only person pretending a knowledge of the healing art" in the area.[11]

Those were the days when practitioners of medicine were often but one step removed from the Indian medicine man in their technical knowledge. Until 1897 Wisconsin law did not require the licensing of doctors and many medical 'experts' entered the field with questionable competence. One pioneer physician tells the story of a typical jack-of-all-trades Wisconsin "herb doctor" who attended a fatally injured woman until she died, then doubled as a carpenter to make her coffin and preached her funeral sermon.[12]

Physicians usually made financial ends meet, not by receiving payment on their services, but by selling a variety of herbs, drugs, and 'Cure Cancer and All Else' concoctions. One common cure-all drug, said to have been prescribed in 22 cases out of 94 by one nineteenth century frontier doctor, was known as Compound Blue Mass.[13]

Like the men, nineteenth century women in medicine often relied upon the sale of these drugs, but their chief duties involved midwifery. Many of them were poorly qualified and, even under the best of conditions, childbirth was a dangerous experience. Midwifery was so entrenched in much of Wisconsin as late as the 1890s that obstetrics was little practiced by competent doctors because only in "cases of the direst necessity" would a midwife call for aid.[14]

One 'midwife' who did not have to call for aid was Dr. Grace McPherson Grant. Born June 25, 1807, in Scotland, she studied at Edinburgh and practiced medicine in Kerr, Scotland, before coming to Ottawa Township, Wisconsin, in 1842. The mother of eight children, she braved wolves and Wisconsin winters to deliver the babies of countless white and Indian women alike. Long before her death in 1883 the Indians of the area had made her famous with the complimentary nickname, "the good White Squaw."[15]

Dr. Clara Frances Tyrrell (1856–1929) was another obstetrician with impeccable credentials. Born in Pittsfield, Mass., she graduated from the University of Wooster in Cleveland at the head of her class. She settled in Fox Lake, Wisconsin, and for many years served the residents of the area.[16]

Unfortunately, not all women in medicine were as reliable as Doctors Grace Grant and Clara Tyrrell.

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[8]Dr. Bertha V. Thomson, "Necedah In Early Days," *Wisconsin Magazine of History,* Vol. 16 (Sept., 1932), 420.

[9]*Ibid.,* pp. 420–422; For an example of Dr. Thomson's early academic contributions see, "Infant Feeding," *Wisconsin Medical Journal,* Vol. 2 (March, 1904), 622–629.

[10]*Waukesha Daily Freeman,* May 30, 1895; Nov. 25, 1897; Nov. 17, 1898; March 10, 1898; See also *WSMS, WAP,* Vol. VI; *Biographies of Physicians and Surgeons,* pp. 570–571.

[11]Peter L. Scanlon (donor), "Practitioners of Medicine in Crawford County," Wisconsin State Historical Society, Manuscript Division (hereafter cited: SHS, MD).

[12]John C. Reeve, "A Physician in Pioneer Wisconsin," *Wisconsin Magazine of History,* Vol. III (1919–1920), 307.

[13]Walter J. Harris, "The Story of Medicine in Wisconsin, 1634–1957," (manuscript), SHS, MD, pp. 3–32.

[14]Dr. J. V. Stevens, "The Pioneer Wisconsin Family Physician," *Wisconsin Magazine of History,* Vol. 17 (1933–1934), 383; Fred W. Riehl, "Brief Reminiscences of Medicine Fifty Years Ago," interview by Margaret Gramling, 1938, in WSMS, WAP, Box #1, Folder #11.

[15]Extract from the *Wisconsin Medical Journal,* March, 1941, p. 240 in *Ibid.,* Vol. XIV.

[16]WSMS, WAP, Box #1, Folder #11.

The medical field was filled with frauds in those days and women seem to have carried their fair share of the burden of deceit. Examples are difficult to document, but one likely candidate seems to have been a Miss S. M. Wells, a self-proclaimed expert in 'electropathy' who appeared for a very short time in Waukesha County in 1862. She advocated a popular notion of the day that the human body was a magnet of positive and negative charges. Illnesses simply followed the interruption of the natural electrical flow in the body. She proposed, by various means, to put things back in order again. Despite the fact that fifteen women testified that Miss Wells was "an intelligent Christian lady," she apparently stayed only the month of March, then disappeared.[17]

But such unsavory examples are heavily offset by women physicians who sacrificed unselfishly for the benefit of their respective communities. At Lima Center, Wisconsin, the wife and husband team of Mary and Robert Stetson treated numerous patients during the last quarter of the century. Mary Hulse Stetson began her career as a school teacher but, because her husband was subject to disabling spells of "inflammatory rheumatism," she decided to become a physician herself. She graduated from Bennett Medical College at Chicago and joined her husband in joint practice. Doctors Julia and E. J. Kelly followed a similar pattern of service at Oconomowoc.[18]

In 1888 Dr. Mary Montgomery, also a graduate of the Bennett Medical College at Chicago, settled in Clinton, Wisconsin, and treated patients there until her death in 1917. She served as both secretary and vice-president of the State Eclectic Medical Society.[19]

Dr. Nancy Elizabeth Newlon Hoyt (1829–1899) assisted her physician husband and then took over his practice at Menomonee Falls when he left to command Company I of the First Wisconsin Cavalry during the Civil War. At his death in 1870 she not only took care of their five children but also sustained his medical practice.[20]

Upon graduating from the Woman's Medical College at Chicago in 1876, Dr. Hannah Russell settled in Sussex, Wisconsin for five years before she moved her practice to Monroe. Like all women physicians who stayed in the profession, she overcame the local prejudice against members of her sex in medicine. She married Felix C. Bennett, the postmaster at Monroe in 1882 and maintained a long and active interest in the Green County Asylum.[21]

Near the turn of the century Doctors Susanne Orton and Jean Mottram Cooke, who had both worked with Jane Addams at Hull House in Chicago, established a medical practice at Darlington, Wisconsin. These women, along with Dr. Mary Gratiot of New Diggings, were known not only for their competent medical skill but also for their activity in a wide variety of community projects.[22]

In 1872 the state hospital at Mendota near Madison attracted the attention of New York born Mary Reynolds (1841–1888). She served at the hospital for nine years before departing in 1880 to take up the formal study of medicine in Chicago. She entered private practice in Milwaukee in 1884 but left shortly thereafter to serve three years as assistant physician in the Northern Hospital at Winnebago. After such a promising early career she fell victim to postoperative complications and died after surgery in Milwaukee in 1888.[23]

Many Wisconsin women physicians were active in state and national homeopathic[24] societies. Another New York born woman, Julia Ford, was the first woman homeopath in Milwaukee. Doctor Ford twice served as treasurer of the State Homeopathic Medical Society. In July 1900 another well known Wisconsin woman physician, Dr. Effie M. Van Delinder of Beloit, attended the International Congress of Homeopathy in Paris.[25]

At home and abroad Wisconsin women pioneered in medical work during the nineteenth century. But women physicians and surgeons were not the only members of their sex who left a lasting imprint on the field of medicine. During the Civil War Wisconsin women became involved in a host of medically related activities in support of their men in battle. Aid societies throughout the state gathered food, clothing, blankets, and medical supplies for shipment south. Mrs. Henrietta Colt of the Wisconsin Aid Society traveled throughout the West supervising the dispersion of these materials. Mrs. Susannah Van Valenburg of Oshkosh accompanied her husband to Virginia in 1863 and served for seven months as a nurse in hospitals

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[17] *Ibid.*, Vol. VIII for clippings from the *Waukesha Daily Freeman*, March 4 and April 8, 1862.

[18] "Reminiscences of Mrs. Ethel Stetson Gibbany of her father and mother, Mary H. and Robert Henry Stetson, practicing physicians in Lima Center, Wisconsin," WSMS, WAP, Box #1, Folder #12; Dr. Harold M. Helm, "Early Beloit Physicians," *Wisconsin Magazine of History*, Vol. 26 (1942 –1943), 301; On Julia and E. J. Kelly see WSMS, WAP, Vol. XVI.

[19] Harold Helm, papers of this Rock County physician and medical historian in SHS, MD.

[20] WSMS, WAP, Vol. XII. One of their children, Melvin A. Hoyt (1857–1925), became editor of the *Milwaukee Daily News*.

[21] *Ibid.*, Vol. XI.

[22] *Ibid.*, Box #1, Folder #12.

[23] Dr. R. M. Wigginton, "Obituary Sketch of Dr. Mary Reynolds of Milwaukee," *Transactions of the State Medical Society of Wisconsin, 1889*, pp. 270–273; Frank, *Medical History of Milwaukee*, pp. 70–71.

[24] Homeopathy was a system of healing based on the motto *Similia similibus curantur*—likes cure likes. The theory went that drugs should be tested upon normal human beings; symptoms caused by drugs in healthy persons were cured, when present in illness, by the same drugs. The effectiveness of the drug was believed to be in inverse proportion to the size of the dose. See *Blakiston's Illustrated Pocket Medical Dictionary* (New York: 1st ed., Blakiston Co., 1952).

[25] On Dr. Ford see Frank, *Medical History of Milwaukee*, p. 50; For a biographical sketch of Dr. Van Delinder see *Biographies of Physicians and Surgeons*, p. 602.

near the front. Jane Jennings, a young school teacher from Monroe, traveled to Washington, D.C. in 1864 to work without pay for Dorothea Dix at the Armory Square Hospital. In addition, many Wisconsin women volunteered their services as nurses at Camp Randall during the Civil War.[26]

The wives of governors of the state were famous for their philanthropic interests. Chief among them was the amazing Cordelia P. Harvey, wife of Louis Harvey who became governor in 1861. Governor Harvey died in April, 1862 in a drowning accident at Savannah near Pittsburg Landing on the Tennessee River while on a tour of the western front. News of the death of her husband almost destroyed Mrs. Harvey. She recovered by dedicating herself to hospital and relief work. Governor Edward Salomon appointed her Sanitary Agent for the west. During the summer and fall of 1862 she toured war hospitals along the Mississippi as far south as Cape Girardeau where the First Wisconsin Cavalry struggled to safety after a frightful expedition into Arkansas. At one hospital Mrs. Harvey "found a corpse which had evidently lain for many hours, the nurses fearing to go near and see if the man was dead." Mrs. Harvey "bound up the face, and emboldened by her coolness, the burial party was induced to coffin the body and remove it from the house."[27]

During the course of the war, Mrs. Harvey visited most of the general hospitals and many of the regimental hospitals in the west. So widespread and thorough were her aid and relief efforts that she became known as "the Wisconsin Angel" to thousands of Union troops. She journeyed to Washington, D.C. and personally pleaded with President Lincoln to establish an army hospital in Wisconsin. As a direct result of this effort, not one but three convalescent camps were constructed in the state. The best known became the Harvey United States Army General Hospital, established in Madison in October 1863. After the war when the federal government decided to abandon the Harvey Hospital, Mrs. Harvey again went to Washington and was granted authority to transform the institution into a Soldiers' Orphans Home. She ran the Home the first year of its existence, acting as mother to as many as 300 war orphans.[28]

Mrs. Harvey, while notable for her dedication and achievement, was only one among many women of Wisconsin in the nineteenth century who pioneered in the establishment of hospitals. Those were the days when some hospitals were so poor that potential patients fought to stay out of them; when the doctors who directed them were frequently known as 'Old Dr. Sawbones'; and when, as one scholar put it, many should have borne the inscription " 'All hope abandon, ye who enter here.' "[29] In addition to individuals like Cordelia Harvey, the sisters of various Catholic orders ended that type of hospital reputation and laid the foundation for many modern Wisconsin hospitals and nursing schools.[30]

Not only did Wisconsin women distinguish themselves in the field of medicine with their administrative ability, technical skill, academic contribution and self-sacrificing attitude, but also they overcame monumental prejudice to do it. Most of them were not only excellent doctors but also successful wives and mothers. Many were political activists, progressives long before progressivism. Taken together they were involved in every major reform movement of their age. Considered individually, some of them were more important to their profession and to the history of their state than men of the period who have received more attention from historians. Wisconsin women involved in nineteenth century medicine left a rich heritage that continued to grow in the present century. In that tradition Dr. Rosa Minoka Hill served the Oneida Indians for almost fifty years before her death at the age of 75 in 1952. Miss Stella Mathews of Milwaukee, an internationally famous Red Cross nurse, was another nineteenth century woman who reached her prime during and after the First World War.[31]

Perhaps the greatest tribute to the pioneering efforts of nineteenth century Wisconsin women physicians were twentieth century women doctors

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[26]Ethel Alice Hurn, "A History of Wisconsin Women in the Civil War," (unpublished B.A. thesis, Univ. of Wis., 1910), pp. 2, 25, 54, 60–62, 75–81, 155–158; Florence C. Dexheimer, ed., *Sketches of Wisconsin Pioneer Women* (Fort Atkinson: W. D. Hoard & Sons, n.d.), pp. 18–21; In 1898, after travel to Europe, Alaska and Hawaii, Jane Jennings joined Clara Barton as a nurse in Cuba.

[27]Quoted from an extract from L. P. Brockett's *Woman's Work in the Civil War* (Boston: 1868), p. 4, in the "Letters and Papers of Mrs. Cordelia P. Harvey, 1862–1864," Wis., State of, Exec. Div.—Administration, Series 1/1/15–17, Box #1, Folder #4, SHS, MD.

[28]See Mrs. Harvey to Gov. Salomon, Oct. 8, 1862, and Salomon to Mrs. Harvey, Nov. 3, 1863, in *Ibid.;* Hurn, "Wisconsin Women in the Civil War," pp. 162–196; Dexheimer, *Sketches*, pp. 47–49, 142–144; The Wisconsin Soldiers' Home at Milwaukee movement following the war was led by Mrs. Lydia Hewitt and other prominent women. See Hurn, *Op. cit.*, pp. 215–233; Dr. William S. Middleton, "The Harvey Hospital," *The Wisconsin Medical Journal*, Vol. 53 (2 parts, April & May, 1954), 226–234, 277–286.

[29]James A. Jackson, "A Survey of the Progress of Medicine During the Past Fifty Years," pp. 68–69, SHS, MD.

[30]The hospital work of Catholic nuns merits an article by itself. See Frank, *Medical History of Milwaukee*, pp. 144–148 on the Sisters of Charity of St. Vincent de Paul who came from Maryland to help establish St. John's Infirmary in Milwaukee in 1848 (the name was changed to St. Mary's in 1858). See Carol M. Oberbreckling, ed., *Saint Mary's School of Nursing, 1894–1969*) (Milwaukee, St. Mary's . . . Alumni Assoc., 1969), pp. 8, 12; St. Joseph's Hospital at Milwaukee and St. Francis Hospital at La Crosse were founded by the Sisters of St. Francis in 1883, Frank, *Op. cit.*, p. 154 and Joseph M. King, "Medicine in Milwaukee in the Nineteenth Century," *Wisconsin Medical Journal*, Vol. 65 (March, 1966), p. 113, and the La Crosse County Medical Society, "Phases of La Crosse County Medicine, 1855–1920," p. 3, SHS, MD; The Sisters of St. Agnes revived a defunct hospital at Fond du Lac in 1896. See "History of Saint Agnes Hospital, Fond du Lac, Wisconsin: 1896–1970," SHS, MD.

like Dr. Elizabeth E. Comstock of Arcadia, Wisconsin, who, before she died on January 18, 1972, after 65 years of professional service as a physician, estimated that she delivered nearly 4,000 babies during her career. The famous "Angel on Snowshoes," Dr. Kate Pelham Newcomb, tramped the backwoods of northern Wisconsin during the 1930s and '40s to deliver more than 3,000 babies without the loss of a single mother.[32] The professional women of the nineteenth century would have expected as much.

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[31] Sally Rogow, "Indian Doctor: Rosa Minoka Hill, M.D.," unpublished manuscript, SHS, MD.; For material on Stella Mathews, recipient of the Florence Nightingale award in 1939 and first president of the Wisconsin Nurses Association, see the papers collected by Mrs. Wayne D. Bird in SHS, MD.

[32] Adele Comandini, *Doctor Kate, Angel on Snowshoes: The Story of Kate Pelham Newcomb, M.D.*, (New York: Rinehart, 1956), *passim;* Harris, *Medicine in Wisconsin*, pp. 69–72; See also, "Dr. Elizabeth Comstock Dies; Deliverer of 4,000 Babies," *The Capital Times* (Madison), Jan. 19, 1972.

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"Small Town" Life in Wisconsin Lures Specialists

Help Alleviate Workload of Family Physicians

FOUR PHYSICIANS in south central Wisconsin are adding a new dimension to health care in three small towns there. They have rejected the much publicized concept of specialized care being available only in big city medical centers.

With the assistance of modern electronic equipment, such as a complex telephone network and electrocardiogram monitors, the four physicians, all specialists, have proven that they can serve a rural area. They stress that their role is to work with family physicians so that all but the most extremely specialized care—such as open heart surgery or neurosurgery—can be delivered locally.

Three of the physicians recently completed residencies and came directly to Wisconsin to practice. MDs Walter Moritz and Frank Nichols, orthopedic surgeons, and urologist David Grout met while in training at Northwestern University Medical School in Chicago. All agreed they wanted to go back to small town life as soon as they could.

The fourth, Ed McNichols, MD, has been in practice for 15 years and his involvement with small town health care has grown steadily.

* * *

"I guess we're sort of pioneers" is the way Doctor Nichols puts it. His point is that instead of practicing in a big city medical center, he, Doctors Moritz and Grout came into a predominantly rural area of Wisconsin. All are happy with the choice.

Doctor Moritz, whose wife's family lives in Evansville, visited the area frequently during his training. On one trip he and Doctor Nichols visited the hospitals in Edgerton, Fort Atkinson and Stoughton, and realized it is possible to see patients in all three towns with fewer commuting problems than going from one side of Chicago to the other.

Last year, their training and military duty out of the way, the three turned their idea into reality. They rented office space in the three towns and were admitted to the medical staffs of the three hospitals. Their central idea was to become "local" doctors for each town and not transport patients elsewhere for treatment.

Both Doctors Nichols and Moritz live in the country—Doctor Nichols between Stoughton and Edgerton and Doctor Moritz between Fort Atkinson and Edgerton. Doctor Grout lives in Fort Atkinson.

A unique telephone hookup allows their widespread practice to function as smoothly as if it were centered in one place. With the cooperation of both General Telephone and Wisconsin Telephone companies, a system was established whereby anyone in the three towns can dial a local number and reach the physicians even if they are in another of the towns.

The telephone directory in each place gives two local numbers for the physicians. The second number is prefixed by the phrase, "if no answer, call . . .". This number rings simultaneously in both of the other two towns. Although a long-distance call, it is free to the caller thanks to special arrangements with the telephone companies and doctors' offices. The system connects telephones in all three of the physicians' offices as well as extensions in their homes.

The business office side of the physicians' practices also is efficiently arranged and well equipped. A central dictation system, available day and night, allows the physicians to dictate letters and reports whenever and wherever they wish. They need only pick up the telephone and dial a series of numbers to hook into the system. Their dictation is recorded on magnetic tape, which is then transcribed by their office staff. Notations for patients' charts can also be dictated. These are transcribed on gummed labels, which are then affixed to the chart kept in the patient's local office. Billing for the three offices is also centralized.

Local part time nursing staffs are in the three offices only on days when a physician will be there. Doctors Moritz and Nichols have office hours three days a week in each town; Doctor Grout's hours are scheduled for one day in each place. All three hospitals are covered daily by the three men.

They stress that their aim is to back up local family physicians. They have designed their role in the medical care system to make sure that the patient is not merely shunted from one physician to another. The idea is to have specialized care available in concert with the care of the family physician.

The three MDs are enthusiastic about their first year in practice. They have built a nine-room clinic in Edgerton which opened in February supplanting their rented space there. Another new

clinic building is slated to open soon in Fort Atkinson.

"Our plans are based on the future," Doctor Nichols says, citing projections which indicate the population will be growing rapidly in the area during the next decade.

However, the three expect the area to maintain its rural character. After all, that's what brought them there.

* * *

Although their set-up is unique, the three young physicians have found that their basic concept is one that was practiced in south central Wisconsin before they arrived.

Ed McNichols, MD, who completed his residency training in Internal Medicine some 15 years ago, today staffs intensive care units in four hospitals.

A board certified internist with special interest in cardiology, Doctor McNichols went into practice in Janesville in 1957. His involvement with hospitals in Edgerton, Fort Atkinson and Stoughton has developed slowly over the last decade.

Today, he is physician-in-charge of intensive care units in the three smaller towns and serves as one of eight physicians staffing Janesville's Mercy Hospital unit.

Although his schedule sounds impossible, he terms it "fun." "It's fun because I have the opportunity to do what I want to do and what I am trained to do," he says.

It all began, he says, because he enjoys teaching. His training of nurses in electrocardiology at Janesville's Mercy Hospital led to his being asked to give similar training in Edgerton when an intensive care unit was set up at Memorial Community Hospital there.

At that time he had been on the Memorial Hospital consulting staff for several years. Today he is physician-in-charge of Memorial's intensive care unit.

No formal structure dictates his role in the care of patients there. It depends on individual arrangements with the family physician involved.

When Fort Atkinson Memorial Hospital was making plans to set up an intensive care unit, Doctor McNichols was asked to help. Again, he trained the staff and acted as administrative consultant. Today, his role there is similar to that at Edgerton Memorial. He sees each patient in the unit and makes daily chart rounds. His degree of involvement with the patients varies with individual family physicians.

Stoughton Community Hospital's four-bed intensive care unit was set up by S. S. Sorkin, MD, of Evansville. His death in 1970 left the unit without a physician-in-charge and Doctor McNichols was asked to take the job.

His involvement with three outlying hospitals has led Doctor McNichols to purchase remote monitors for viewing electrocardiograms. One is in the Janesville office, where he can be found almost every afternoon; the other is at his bedside. He, his wife, and their 12 children live outside Janesville near Milton.

At Doctor McNichols' request, a nurse can push a button in the hospital and flash an electrocardiogram to his home or office monitor.

"Because I trained the nurses myself, I know their capabilities and find it easy to work with them," he says.

He admits that his schedule of daily rounds in the three outlying hospitals in addition to his Janesville practice is hectic.

"But the thought of educating my 12 children spurs me on," he says.

Reimbursement for his activities at the Edgerton, Fort Atkinson and Stoughton Hospitals varies with his duties. The hospitals underwrite some of his services, such as teaching nurses and administrative duties. Patient care is on a fee for service basis.

Like the three younger MDs, Doctor McNichols says he is fighting the concept of specialized medicine being concentrated in the big city centers. But besides that, he says, he finds the whole hectic setup challenging and rewarding. □

ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

UNANIMOUS TASK FORCE VOTE

Watchdog Health Services Commission Recommended

"What you see is what you get."

That, in effect, is what Health Task Force chairman David Carley said October 24 to assure Task Force members that agreeing to recommend establishment of a watchdog Wisconsin health services commission would not be buying a "pig in a poke."

At the major meeting of the Task Force's existence, the group endorsed the commission, a public utility approach to regulating state health care.

Public Utility Concept

This rule-making body would have a lot to say about what physicians, hospitals, and other types of providers could—and could not—do. Like a public utility, it would be concerned with state franchising and control of people and institutions in the field —in this case, the health care field.

Milwaukee attorney Dennis Purtell (son of State Medical Society President Robert F. Purtell, MD, Milwaukee) had protested that the Task Force was being asked to pass on only a "skeleton" of the health services commission. He said the proposal was too vague to pass on without knowing what would be in the legislation creating the commission. Mr. Carley said drafting of actual legislation to carry out the idea would be done by "the experts."

According to its present "skeleton" form, the commission would have statewide authority over:

RATES of health care institutions. "Other factors of health care costs" (presumably including physicians' fees) would be evaluated.

LICENSING of health care institutions (but not private practitioners' offices);

NEED for additional health care institutions (which may include physicians' offices); and

QUALITY review of health care.

One previously proposed aspect of the commission was discarded between the Task Force's September and October meetings. This was a suggestion that the commission also be a bonding authority to help institutions raise money for expansion projects.

Bonding Authority Dropped

The Wisconsin Supreme Court is currently considering the constitutionality of this approach in connection with a state housing bonding authority law which was passed during the last session of the Legislature. Because of the pending court rulings, the Task Force made no recommendation on health institutions' bonding.

How necessary is the utility?

Gerald J. Derus, MD, president-elect of the State Medical Society, pointed out in a letter to the Task Force that much of what the utility would do has already been started by voluntary groups and the State Division of Health:

RATES of hospitals are being reviewed by Blue Cross and the Wisconsin Hospital Association;

LICENSING is already operating under the Division of Health and with relatively modest improvement could achieve the same goals as those being proposed;

NEED for additional health care institutions is now a comprehensive health planning task;

continued on next page

Alert to Members!

DEADLINES for 1973 ANNUAL MEETING Events

January 25
Resolutions for the House of Delegates due in Secretary's office

February
Early publication of the *Wisconsin Medical Journal* with inclusion of major portions of the Annual meeting program and summaries of the resolutions

March 24
Council meeting

March 25–26–27
House of Delegates sessions

March 26–27
Scientific Program

QUALITY review of health care is being developed through Wisconsin Health Care Review, Inc. (WHCRI), a nonprofit corporation established last December by the state medical, dental, and hospital groups.

Indeed, the utility would rely on some of these efforts (such as Blue Cross rate review and WHCRI quality review) to do its work.

One job the commission would have to do itself, however, according to Chairman Carley, is licensing of health care institutions. What is a "health care institution?" Task Force members hammered out specific wording here. Licenses would be required for institutions "such as, but not limited to: hospitals, nursing homes, county homes, and home health agencies, excluding private practitioners' offices."

The last four words were an amendment suggested by Stanley Graven, MD, director of the Wisconsin Newborn Center at St. Marys Hospital Medical Center, Madison. He pointed out that "there is a long track record with licensing of hospitals, but no experience with individual offices."

"Nod" to Division of Health

However, data collection and inspections for licensing may be delegated "to other organizations," according to the recommendation. Mr. Carley said this is a "nod" to the Department of Health and Social Services.

George Handy, MD, Madison, state health officer, offered an amendment specifying the Department of Health and Social Services as data collector and inspector. A Task Force vote rejected this change.

Mr. Carley said that a companion to the health services commission's power to license institutions is its administration of the certificate of need program recommended by the Task Force. Certificate of need means the commission would have to approve any project over $100,000 by a health care institution to expand or change its facilities or services.

Added Paperwork

John R. Peterson, MD, Milwaukee, medical services director for Milwaukee County General Hospital, expressed some concern about what this would do to that hospital's already cumbersome budgeting process. Dr. Peterson said he agreed with the idea, but felt such added paperwork would make his job impossible.

Richard Shropshire, MD, Madison, president of the Wisconsin Academy of Family Physicians, wanted to know if physicians' offices were "health care institutions" subject to scrutiny under certificate of need. He said if so, physicians might not be too interested in constructing facilities in Wisconsin.

Dr. Graven objected to wording specifically excluding physicians. Besides, he said, "if there is a need, they wouldn't be turned down, so I don't see the problem."

Changes in Wording

Peter Eichman, MD, former University of Wisconsin Medical School dean, said physicians' offices should not be put in the same category as hospitals because a "physician's practice is substantially different than a hospital." He pointed out that, unlike hospitals, physicians' offices receive no tax break and bear full liability for actions performed there.

Ben Lawton, MD, Marshfield, vice-chairman of the Task Force, didn't see that problem. He said "hospitals and MDs are in the same position and should work together . . . I think the health planning people would be jumping up and down to approve the (MD) office every time."

A vast majority of the Task Force members seemed committed to the idea that certificate of need should apply not only to hospitals and nursing homes but also to surgicenters, pathology and radiology facilities, and the major clinics. At the same time there seemed unanimous agreement that the one or two man physician offices should not be under certificate of need. If this idea would be turned into a workable rule, it would make Wisconsin unique.

When the Task Force finally voted, it included physicians' offices under certificate of need if they "provide services regularly provided by health care institutions." The only dissenting vote was Earl Thayer, State Medical Society secretary. It now seems that some changes in that wording may still be possible before or during the final Task Force meeting on November 17.

Medical Staff Rules

The Task Force's certificate of need recommendation also includes some rules on physician staffing of the health care institutions which receive certificates. Such institutions "must process the application for medical staff membership" for all licensed physicians who go through the institution's regularly established procedures. Original wording would have required these institutions to open their staffs to any licensed MD who applied. It was changed when Mr. Purtell pointed out that these institutions should not be forced to admit every physician who applies.

Amid all this proposed government control, a major achievement for the health care professions came in the Task Force recommendation that quality review of health care be done by "a publicly chartered but nongovernmental body or bodies." Wisconsin Regional Medical Program (WRMP) director, John Hirschboeck, MD, Milwaukee, shepherded this proposal through the Task Force along with Task Force staff member Marc Hansen, MD, of the University of Wisconsin Medical School, Madison. The health services commission would set the standards and conditions of the review organization's charter. The original proposal here had been for the

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

"Super Group" for Health Planning?

The much discussed "super group" of health planning, the Health Policy and Program Council (HPPC), has now been given its final blessing by the Governor's Health Task Force.

Someone has quipped that the HPPC will be so powerful that its chairman, Ben Lawton, MD, Marshfield, will be Wisconsin's "health czar."

The HPPC was the first item the Task Force acted on at its arduous October 23–24 meeting. However, who will choose the HPPC's 45 members, exactly what they will do and how, is not clear.

The Task Force spelled out only the following basics:

ONE. HPPC should be a permanent body, established in state law. As it is now, HPPC exists only by an Executive Order which will end when Governor Lucey leaves office.

TWO. Until that happens, Governor Lucey should strengthen HPPC through a new Executive Order. HPPC now can only oversee five state health agencies which have federal funding: comprehensive health planning, developmental disabilities, hospital construction, mental health centers' construction, and facilities for the mentally retarded. The Task Force proposed that HPPC be made the top health policymaking body in the state. This means everything from the medical schools in Madison and Milwaukee to health related programs of the Department of Agriculture, Public Instruction, vocational schools and the Department of Health and Social Services. On top of this, and probably most significant, HPPC would have some absolute veto power over health program funds in state agencies and departments, even though they were acting within the authority granted them by the Legislature.

THREE. HPPC's staff should come from the Office of Comprehensive Health Planning.

FOUR. Money for HPPC should come from the programs it administers.

FIVE. HPPC's members should represent consumers, providers, government and each areawide ("B") comprehensive health planning agency. There should not be more than 45 HPPC members. (In the example cited by the Task Force in its background paper, 18 of the 45 members would represent "providers," but only one of those would represent "medicine.")

Two important unanswered questions are:

ONE. Who will pick HPPC's members? Here, the Task Force's background paper on HPPC contradicts itself. One part says that groups represented could choose their representatives. Another section says that the Governor would appoint HPPC's members from "a slate of potential nominees" presented by various groups and screened by HPPC. Sensing the real source of power, State Senator James C. Devitt (R-Greenfield), a Task Force legislative advisor, at one point said there should be a separate vote on HPPC's members. However, no such vote was taken.

TWO. Where will HPPC fit in state government structure? Before the Task Force took its final vote on HPPC, George Handy, MD, Madison, State Health Officer, made a final plea to keep it within the Department of Health and Social Services. Again, the issue was not resolved by the Task Force.

It seems both questions will have to be answered by the Governor and the Legislature.

Watchdog/continued

Health Services Commission to do the review itself.

The Task Force agreed to a suggestion by Mr. Thayer that those participating in this quality review would be legally assured of immunity from prosecution in connection with their work.

The Commission would be composed of three full-time commissioners appointed for staggered terms of six years. They would be advised by three nine-member program councils, one each on rate review, licensing, and quality assurance. This, according to Mr. Carley, involves members of the professions and the public in the commission's work. The chairman of each of these councils would be appointed by the chairman of the Health Policy and Program Council (story on this body appears elsewhere in this issue of the GREEN SHEET).

More Task Force Recommendations

The Task Force has made a great many recommendations for changes in mental health, alcoholism, drug abuse, and developmental disability services in the state. Space permits only the following run-down:

"Home rule" by county or multi-county boards of state funds for mental health, developmental disabilities, and alcoholism treatment services in that area. (See September GREEN SHEET.

"Ability to pay" charges for patients receiving services through their counties.

Top priority in mental health clinics for "adequate pre-care and after-care programs for severe and chronic disabilities: the psychotic, the alcoholic, the drug abuser, and the developmentally disabled."

High priority for development of alcoholism treatment programs and child–adolescent mental health services.

Treatment of public drunkenness as a health problem by removing it from the statutes as a criminal offense.

Hospital-based alcoholic and drug detoxification services in every area of the state.

Screening by court appointed professionals of all petitions for commitment to mental institutions and additional safeguards for the civil rights of those being committed.

Limitation of 48 hours on emergency detentions of the mentally ill, alcoholic and chronic drug abusers. Such detentions should be in health facilities only and insure civil liberty protections.

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Alternatives to long-term, inpatient care for mental health problems. Suggestions include day and evening outpatient and activity centered programming, halfway houses, family care facilities, emergency and outreach services."

Special training in "a preventive approach to mental health" for primary health care professionals and in alcoholism and other drug abuse "for all health and mental health professionals."

"Social rehabilitation services directed toward community living" for the non-acute patients now in county mental hospitals.

"Support and services to those currently residing in county mental hospitals."

Review and audit of "all alternatives to county hospitals, including residential care facilities and public medical institutions."

Change in subsidies for both outpatient and inpatient care. (See September GREEN SHEET.) Those having over a year of inpatient care would be reviewed to determine where to place them.

"90% charge-back to the counties for county residents admitted for acute treatment beginning July 1, 1974."

Funding priority for child and adolescent services at the community level and phase out of acute inpatient treatment for children and adolescents in the state mental hospitals by July 1, 1975.

State support for regional interdisciplinary consultant teams on children's problems.

State administered aids "for those disabled by drug dependency."

Insurance coverage for outpatient mental health care "with no exclusions for services in public facilities" and coverage for personnel other than psychiatrists.

Changing Winnebago and Mendota state hospitals to "Mental Health Institutes" for specialized care, research and training.

Closing Central State Hospital and moving its inpatients to either of the "Mental Health Institutes."

Reducing the size of the colonies for the developmentally disabled and stressing shared responsibility between the state and the parent.

Expanding developmental disability services such as genetic counseling, community living for adults, legal protection, and assuring accountability of educational services.

Public education about the nature of and capabilities of the epileptic.

Mandatory education from kindergarten through 12th grade on "Critical Health Problems," a curriculum on such topics as alcohol and drug abuse which is now taught on a sporadic basis in some schools.

Evaluation by the Bureau on Alcoholism and Other Drug Abuse of drug information and abuse programs' staffing and content before July 1, 1973. Results of this evaluation would determine future funding of such programs.

Study by the Health Policy and Program Council with the Dangerous Substances Control Council of "the health and policy implications of present legislation controlling the use and possession of illegal drugs."

Leadership by the State Medical Society, the State Pharmaceutical Association, and other professional associations "in creating the means to restrict the improper prescription and use of mood-altering drugs."

State Medical Society review and development with other health professionals and allied personnel of standards for non-psychiatric medical and nursing care in Wisconsin county mental hospitals. "These sections will report their recommendations to the Health Policy and Program Council by February 1 to be published as new rules by July 1, 1973."

Task Force Wants CHP Under Governor's Control

Comprehensive health planning (CHP) in Wisconsin (the "A" agency) has always been administered through the Division of Health in the Department of Health and Social Services. The Task Force has recommended that this job now be taken out of the Division of Health and placed in an office under the direct control of the Governor.

As might be expected, this is a controversial proposal. It grew out of the basic need to establish CHP in state law.

When the Division of Health got the job in 1967, CHP was "a federal program passing through a state conduit," as one planner has put it.

No state law was enacted making CHP a state project. When CHP was put into the Division of Health, it was purely an administrative decision. If federal money for CHP programs dries up, there is now no legal rationale at the state level to continue them.

Some feel that making CHP wholly responsible to the Governor puts the job too much in the political arena. The Task Force defeated a motion by George Handy, MD, state health officer, that the CHP director be a civil service employee. The Task Force recommended that the CHP director be appointed by the Governor, but that his staff be civil service.

CHP would be "advised" by the Health Policy and Program Council, made up mostly or entirely of the Governor's appointees.

The Task Force also recommended that the state's comprehensive health planning agencies —statewide ("A") and in each administrative district ("B")—be fully developed by 1975.

Task Force Asks New Uses of State Funds for Private Health Care

Three new approaches to paying the health care bills for some Wisconsinites were approved by the Governor's Health Task Force at its omnibus meeting October 23–24 in Middleton.

The Task Force recommended financing:

. . . to make health insurance available to people now considered "uninsurable" by health insurance companies;

. . . to pay for health care costs beyond the means of most citizens—special categorical care and economically catastrophic illness;

. . . to give state employees a chance to try new types of health insurance plans.

Insurance for the "Uninsurable"

Health insurance for the "uninsurable" is an idea proposed by the State Medical Society last spring. It is aimed specifically at people unable to obtain regular insurance because of poor health.

The Task Force asked that all Wisconsin health and accident insurers be required to participate in offering this type of coverage. It also recommended that people financially unable to pay for it and who are not eligible for public assistance have their insurance premiums paid by the state.

Health insurers will no doubt lose money on the "uninsurables" they cover. Realizing this, the Task Force recommended that the state pay for a percentage of this loss. Details here are to be worked out by the health insurance industry with the State Insurance Commissioner.

All members of the Task Force agreed to this proposal with the exception of Robert R. Cadmus, MD, executive director of the Medical Center for Southeastern Wisconsin, Milwaukee. He objected that this would be "preferential treatment for a certain group" and would be "discriminatory to the poor who are healthy."

Catastrophic Illness

Whopping medical bills for a major illness or chronic long-term problems such as renal disease and perinatal care can bankrupt a family. The Task Force recommends that such problems "be accepted as a public responsibility to be shared by all, rather than to be paid by the few victims."

The Task Force refused to single out one or two kinds of problems for public funding. Pressure in this direction had been exerted in the last session of the Legislature by the Kidney Foundation and the Wisconsin Association for Perinatal Care. Instead, the Task Force, in effect, accepted the State Medical Society's position here. That position states that all conditions of catastrophic significance to the consumer be brought under some kind of catastrophic protection plan (either voluntary or government).

One of the big questions is *when* a citizen is eligible to receive public aid. Does he first have to go bankrupt? Or can he still have a few dollars saved? This problem has been left to the Health Policy and Program Council.

State Employees Insurance

Between its September and October meetings, the Task Force tossed out the idea of developing an innovative prepaid health care plan for Dane County residents. Instead, it recommended that state employees be able to choose from among a number of different types of "health care plans that offer various methods of delivering and paying for health care including alternatives to fee-for-service such as prepaid capitation and prepaid group practice." Because there are close to 40,000 state employees, most of the Task Force members felt this much purchasing power would provide real incentives to health insurers to offer innovative types of plans. The state would "pay a specified dollar amount per month toward health insurance" and let the state employees choose from general approved plans. Each year the employees would have an opportunity to change plans.

Task Force Calls Chiropractic "Unproven" and "Uncontrolled"

Chiropractic was described as **"academically unrecognized, scientifically unproven and medically uncontrolled"** in the final report of the Chiropractic Study Committee of the Governor's Health Planning and Policy Task Force.

In a report to the full Task Force, the three-member committee said **"overwhelming evidence exists to demonstrate that chiropractic theory and practice have no scientific validity, and do have the potential for doing substantial physical harm."**

The report rejected chiropractic on the basic Task Force premise "that every citizen of Wisconsin has the right to quality health care." The committee recommended these ways to combat chiropractic:

EDUCATE Wisconsinites on "the nature of chiropractic theory, its lack of scientific validity, and the potential hazards associated with its use."

OPPOSE any legislation requiring "that coverage for chiropractic services be included in any form of insurance policy."

REFUSE "the use of any public resources for any purpose which would tend to further the use of chiropractic."

ENACT legislation "to remove chiropractic services from coverage by the Workmen's Compensation Law."

DIRECT the Basic Sciences Examining Board "to reexamine regularly the standards for successful completion of the basic sciences examinations in those states with which applicants seek reciprocity."

It based its recommendations on a review of "the wealth of existing literature available on the theory, practice and scientific foundations" of chiropractic.

Visited Palmer College

Committee members also vis-

continued on next page

Outcome of Task Force Recommendations Considered

In addition to all of the Health Task Force recommendations covered in other stories in this GREEN SHEET, many others were made in October ranging over a wide variety of topics.

Space permits only a brief summary of what would happen in each area if the Task Force's recommendations were carried out.

Some of these have been dealt with in more detail in the July, August, and September issues of the GREEN SHEET.

All of the quotations are taken directly from the Task Force's recommendations.

Environmental Health. Two bodies would be set up to deal with environmental problems and planning. One would be "a comprehensive environmental planning body" tied to the Governor and the Legislature. The other would be "an Environmental Health Resource Center" within the University of Wisconsin system. This would also advise the Governor and the Legislature as well as providing professional training and public education.

School Health. A pilot project would be set up to show "what can be done in the schools to improve the delivery of health services to children." Also the Governor would establish the School Health Services Committee—to "develop legislation requiring that selected health services be provided in all Wisconsin schools."

Consumer Health Education. A state Health Education Policy Committee would be set up as part of the Health Policy and Program Council. "This committee will provide leadership at the state level for all consumer health education efforts, including school health education." Areawide health education committees would also "be established by each of the eight Areawide Comprehensive Health Planning Agencies (AHECs) to coordinate all areawide and local programs in health education, including school health education.

Health Insurance Standards. The insurance commissioner would be able to establish minimum standards for health insurance to standardize and simplify contracts, eliminate deceptive, misleading or confusing language and make coverage "consistent with the health care needs of the public."

Medicaid. The Attorney General would be asked if there is a legal barrier to prepaid health care services for Medicaid recipients. If so, the statute would be modified. If not, the Division of Family Services would immediately "provide for the enrollment of Medicaid recipients in prepaid health care plans." The Task Force also called for consumer education on eligibility for Medicaid; provision for equal availability of Medicaid "to the indigent population between 19 and 65 years of age;" and a quality assurance program to improve Medicaid standards. (The latter has already started in nursing homes and the colonies through a contract between the state Division of Family Services of the Department of Health and Social Services and Wisconsin Health Care Review, Inc. (WHCRI). (See August GREEN SHEET).

Continuing Education. Regional continuing education committees would be formed by the University of Wisconsin Extension system "to identify and meet" the state's needs. The Health Policy and Program Council would measure "the im-

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Chiropractic continued

ited Palmer College in Davenport, Ia., where nearly half of Wisconsin's chiropractors were educated. It found many of the faculty and students to be sincere and dedicated, but overall deficiencies "too pervasive to permit an adequate educational experience."

The committee was particularly concerned about inadequate training in the use of X-ray equipment, a principal tool of most chiropractors. They asked that qualified experts study dangers to patients from excessive exposure to radiation and that "such regulations as are appropriate be enacted and enforced."

They summed up the hazards of chiropractic this way:

ONE: "chiropractic treatment frequently delays effective medical care until it is too late;

TWO: "it often aggravates conditions that would otherwise have been readily amenable to proper treatment"; and

THREE: "it sometimes produces actual physical damage to patients."

Immediately after the study committee asked the Task Force to adopt its recommendations, the report was vigorously attacked by the Wisconsin Chiropractic Association.

Calling the report "spurious" and "intellectually dishonest," chiropractic representatives launched a two-hour barrage criticizing the committee, the entire Task Force, medical societies, and previous studies of chiropractic.

Caustic Comments

Carl E. Lauri, executive secretary of the Wisconsin Chiropractic Association, aimed particularly caustic comments at committee member Robert Durkin, a Milwaukee labor leader.

"I am shocked at Mr. Durkin lending his signature to this report," he said. "Perhaps he ought to read some of the labor resolutions supporting inclusion of chiropractic coverage in insurance, in all insurance."

Committee Members

Other committee members are Milwaukee Attorney Gilda Shellow and William Blockstein, a University of Wisconsin pharmacy professor.

In a brief rebuttal, Mrs. Shellow told the Task Force that the report's bibliography would confirm that the committee had communicated with chiropractors and had researched some materials chiropractors charged had been ignored.

The Task Force then voted unanimously to accept all of the report's recommendations.

Outcome continued

pact of continuing education programs for health workers on the health workers themselves and the public they serve." The UW Extension would also set up "a central information service for all continuing education programs for health workers within the state."

Health Care Guidelines. A series of 34 guidelines make up "a general framework for formulating health policy, for health planning and for citizen understanding of the health care system." Examples of what the guidelines advocate are: a consumer role in health care delivery, defining service areas according to geography and population, upward mobility in the health professions, and an organized emergency care system. (The State Medical Society will provide copies of the complete set of guidelines on request.)

Research and Development. A committee of the Health Policy and Program Council would monitor and coordinate a research and development program in Wisconsin. The program would include three services: (1) to seek out problems and ways to solve them, (2) to develop and test solutions to health delivery problems, and (3) to help implement improvements.

Emergency Medical Services. The state's areawide comprehensive health planning agencies ("B") would have to develop a plan for emergency ambulance service by July 1, 1974. The state comprehensive health planning agency ("A") would check to see that such a plan was developed. The state Department of Health and Social Services would prescribe rules and regulations for operating the plan and would also establish a system of classification of hospitals based on their emergency medical services. (All of this has been initiated by the Wisconsin Regional Medical Program Service with a million dollar grant for an Emergency Medical Service system.)

The Elderly. State funded programs for the elderly—particularly Medicaid—would be altered to emphasize preventive services and noninstitutional care. The Health Policy and Program Council and the Division on Aging would work with other agencies to help the elderly remain in their own homes, to prevent needless institutionalization, and to develop training programs for health care personnel in dealing with the elderly.

Health Information. The Department of Health and Social Services would establish a Health Data Center to coordinate and aid in the department's "existing health data functions." Also, "the Health Policy and Program Council should provide for Wisconsin participation in the federal–state–local health statistics system."

Generic Prescribing. A Drug Quality Review Board consisting of physicians, pharmacists, and others would "prepare a formulary of prescription drug products deemed clinically effective and chemically equivalent ranked in order of wholesale cost." The pharmacist would use this to determine which prescription drug product to dispense based on the lowest available wholesale cost "unless the prescriber specifically withholds such authority from the pharmacist."

Health and Social Services. The development of local multicounty, single county and city/county public health agencies would be developed with help from a state grant-in-aid program developed by the Department of Health and Social Services (DHSS). (Such public health agencies have been supported by the State Medical Society since the early 1950s.) The state would try to bring its health programs into conformance with the eight state administrative districts. In each of these districts, there would be an areawide DHSS administrator who would be in charge of all DHSS programs in that area.

Tuberculosis. An Advisory Committee on Tuberculosis would be appointed to advise the Division of Health on tuberculosis care standards. Inpatient care in tuberculosis sanatoria would no longer be subsidized by the state but acceptable outpatient care could continue to be subsidized. Health insurance sold in Wisconsin could not exclude coverage for TB treatment. Certified facilities for acute, inpatient care of tuberculous patients would have to meet state standards for general hospitals. A network of outpatient TB treatment resources across the state would be promoted by the Department of Health and Social Services.

Task Force Also Keys in on Health Manpower Problems

The increasing demand for health professionals has many facets. The Governor's Health Task Force made recommendations dealing with almost all of them.

Probably as important as any is one suggesting that an institution be licensed and then be free to hire personnel as it saw fit. If it chose, the institution could ignore any particular professional licensure requirements of the state. A demonstration project would be set up based on the recommendations of that "super group," the Health Policy and Program Council (HPPC). (See story elsewhere in this GREEN SHEET.)

The thinking behind institutional licensure revolves mainly around health maintenance organizations and national health insurance. The reasoning is that these two developments will require institutions to be responsible for providing care to designated populations. Therefore, the institutions should "have the ability to utilize and control the actions of their employees and direct such action to provide quality care."

Employment of Physicians

Since the Task Force is proposing virtually unlimited employment of physicians by

continued on next page

hospitals, it is easy to imagine that such a development would place almost total control of health care delivery in the hands of institutions.

Professionals who are licensed would no longer have one-time, lifetime licensure according to another Task Force recommendation. Instead, health professionals' knowledge would be regularly evaluated. Presumably, if a professional were found wanting, the ultimate step would be loss of license. Exactly how this would work was left to the state's quality review agency to figure out and advise the HPPC.

Health professionals out of practice for more than a year would also need to prove their competency before receiving a license renewal. What that proof would be was left up to the licensing board. However, it would need to be some sort of "certification by an institution or employer."

An addition of two new members of each licensing board was another Task Force recommendation. One would be a lay member and the other would be a "member of a health profession other than the one being licensed."

The state's far flung health education network also received attention. Again, sitting at the top is the "super group"—the HPPC. Its Health Manpower Committee would advise it "on matters relating to the education of health professions and health manpower," according to a recommendation adopted by the Task Force October 24. This committee would be made up of representatives from public and private institutions and AHECs (Area Health Education Centers).

The AHEC (see July *Wisconsin Medical Journal*) is also a Task Force idea. It is a not-for-profit corporation made up of consumers and providers who would work with health planners on determining and meeting an area's health manpower needs. The Task Force has asked the Wisconsin Regional Medical Program (WRMP) to set up pilot AHECs in the state to see if they work. If they do, a statewide network would then be developed.

Update for Nursing

An example of what the Health Manpower Committee would do is suggested by a Task Force recommendation on nursing. It would "develop an annually updated plan for nursing and nursing education." This would include "policy recommendations regarding the proposed development of new programs or the expansion in scope or enrollment of existing programs."

Another committee—this time a legislative one—would be created to take a look at the fast proliferating new types of health professionals. This is something the State Medical Society has proposed for years—a legislative joint survey committee. Such a committee would consider any legislation affecting licensing laws for health professions. At the request of state nurses, the Task Force asked that the committee also "study the Nursing Practice Act and modify it to reflect the changing practices in nursing."

Pending creation of such a committee, the Task Force said that the Governor should declare a moratorium on new health professional licensing and certification. Just such a moratorium was called for by the American Medical Association in December 1970. One member of the Task Force noted that as it is now, "any group can pressure the Legislature into approving another type of licensing."

Physician Assistants

The perennially sticky question of physician assistants was not dealt with by name. However, the Task Force did recommend that "individuals properly trained to perform health service functions" be legally able to take responsibility delegated to them. Presumably, the authority to delegate would be built into a physician's license (or that of a nurse, dentist, etc.).

The Task Force did recommend creation of one new type of health professional—a "Doctor of Psychological Medicine." This would be a non-physician mental health professional who could practice independently and use drugs.

Peter Eichman, MD, Madison, former dean of the University of Wisconsin Medical School, made the proposal on behalf of the UW's Department of Psychiatry. Dr. Eichman said that the director of the National Institute of Mental Health has expressed an interest in the idea.

"Community-Oriented Services"

A synopsis of the proposal says that "present psychiatric education, with its traditional medical background, is unnecessarily time consuming and irrelevant to training mental health clinicians. It also tends to emphasize private office and hospital practice at a time when the need is for community-oriented services to all citizens."

To enter the training program, two years of college would be necessary. After four or five years of work, the trainee would be awarded a clinical doctoral degree. "At least one year of clinical service in a high-need area of the state would be required as a prerequisite for the degree," according to the synopsis.

Dr. Eichman stressed that "upward mobility" is built into the program. "Any required course could be waived in favor of credit by written and practical examinations," the synopsis says.

"Make Up Deficiencies"

"This would enable professionals from related fields to finish the program in a much shorter time. They would be allowed to demonstrate prior knowledge and competence and required only to make up deficiencies. Thus, psychologists or social workers who can demonstrate clinical competence need only concentrate on the biological aspects; conversely pharmacists or nurses might require relatively little biological training."

The Task Force also made a number of recommendations on nursing education, including provision for upward mobility, the expansion of masters degree programs, and the initiation of doctoral studies for nurses.

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State Medical Society of Wisconsin

MARCH 26–27

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THEME: EVALUATION AND THERAPY OF COMMON ENDOCRINE DISORDERS

Monday, March 26

A.M. Plenary Session, Sections on Family Physicians, Internal Medicine, Pediatrics

Noon Socio-economic Luncheon. Speaker to be announced.

P.M. Plenary Session, Wisconsin Allergy Society, Sections on Dermatology and Public Health

Tuesday, March 27

A.M. Resident–Intern Papers Program
Plenary Session, Sections on Pathology and Radiology

Noon Roundtable Luncheons

P.M. Anesthesia, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Pathology, Radiology, Surgery

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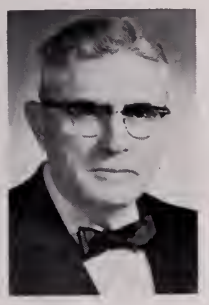
NEWS HIGHLIGHTS

Dr. Ralph Landis of Appleton Honored

On October 21 members of the medical profession from Appleton and other Fox Valley cities honored Ralph V. Landis, MD* by establishing a scholarship in his name at Lawrence University with an initial gift of $10,920.

The fund was announced at a ceremony in which the University's Health Center was named for Doctor Landis. More than 200 persons gathered to pay tribute to a man who has practiced medicine and surgery in Appleton for nearly half a century. He also has been physician for Lawrence University and its athletic teams for 46 years.



Dr. Landis

Co-chairmen of the scholarship fund drive were MDs Gilbert F. Mueller, Jr.* and James M. Sargent.* Doctor Mueller compared the idea of a scholarship fund to a seed which "fell upon fertile soil indeed, namely, the tremendous admiration which we all have for Doctor Landis and our respect for the University he has served so well."

In a letter transmitting the $10,920 to the Lawrence University trustees, Doctors Mueller and Sargent said: "Lawrence alumni and other friends of Doctor Landis and the University are encouraged to carry on this project. . . . It is the purpose of the donors that the earnings of the fund will be used to provide financial assistance to deserving Lawrence students, preferably those pursuing a career in medicine."

Lawrence University President Thomas S. Smith unveiled a stone tablet bearing the inscription, "Ralph V. Landis, M.D., Health Center," and the caduceus.

John S. Millis, president of the National Foundation for Medical Education in Cleveland, Ohio, described Doctor Landis as "a magnificent primary physician who takes responsibility for the whole person." Mr. Millis was a faculty colleague of Doctor Landis and is now president emeritus of Case Western Reserve University and chairman of the President's Panel on Heart Disease.

Responding to these honors, Doctor Landis said that when he learned of plans to rename the Health Center for him, "I began to realize I had friends." His usual "deep-down humility" began changing to pride, "not in what I've accomplished, but that people rallied around when they were needed."

The Health Center, which will bear Doctor Landis' name, was built in 1966 and has 16 beds. Additional bed space for up to eight more students can be provided.

Doctor Landis has been a member of the Outagamie County Medical Society since he came to Appleton in 1925. For many years he served as its secretary. He also has been a member of the Wisconsin Surgical Society since 1935.

He received his medical degree from Rush Medical College of the University of Chicago in 1925 and interned at Cook County Hospital. In 1926 he was appointed part-time college physician and lecturer in hygiene at Lawrence University. He has been associated with the University ever since, although his lecturer duties were discontinued when he returned from military service in World War II.

Wisconsin Orthopedic Society Elects

Paul W. Phillips, MD* of La Crosse was elected president of the Wisconsin Orthopedic Society at its September meeting. Stephen L. Haug, MD* of La Crosse was elected secretary.

PHYSICIAN BRIEFS

Donald R. Griffith, MD*

. . . Eau Claire, recently was elected to serve on the Board of Trustees of the American Association of Medical Clinics. Doctor Griffith, a member of the medical staff of the Midelfort Clinic, also serves as his group's official delegate to the AAMC.

David S. Dahl, MD*

. . . Middleton, presented the scientific lecture at the September 21 meeting of the Jefferson County Medical Society. His subject was "Muscle Disease."

Dr. Freeman

J. M. Freeman, MD*

. . . Wausau, recently was honored at a "Joe Freeman Recognition Dinner" for his 53 years of service to the community. Development of the Freeman Medical Group, the Wausau Clinic, and now the Wausau Medical Center were cited in testimony to the doctor's leadership in the 53 years of his practice which he plans to continue. Dr. William S. Middleton,* Madison, dean emeritus of the University of Wisconsin Medical School and Distinguished Physician of the Veterans Administration, was among the many friends who attended the dinner and spoke in behalf of Doctor Freeman's dedication to his profession.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

PHYSICIAN BRIEFS . . .

George A. Behnke, MD*

. . . Kaukauna, gave the dedication address at the open house event in October for the new Community Memorial Hospital at Oconto Falls which officially opened in March. He is immediate past president of the State Medical Society. The 104-bed hospital, built at a cost of $2.1 million, replaced a 52-bed hospital which had served the area since 1921. The new building is located on a 17-acre tract which provides quiet surroundings and a scenic view.

Andrew B. Crummy, MD*

. . . Madison, has been appointed acting chairman of the Department of Radiology, University of Wisconsin–Madison Medical School. He will serve as acting chairman while John H. Juhl, MD* is on a six-months leave of absence as visiting professor of radiology at the Charles Drew Post Graduate Medical School in the Wilmington–Watts area of Los Angeles. A graduate of Boston College's School of Medicine, Doctor Crummy served his residency at University of Wisconsin Hospitals and joined the medical faculty in 1963. He was promoted to full professor last July.

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NEWS HIGHLIGHTS . . .

Wisconsin Otolaryngological Society Officers

Roger Lehman, MD* of Wood was elected president of the Wisconsin Otolaryngological Society at its meeting in September. The secretary is Timothy J. Donovan, MD* of Madison.

Seventy-one State MDs Become Charter Fellows, AAFP

On September 26 in New York City the following Wisconsin physicians became Charter Fellows of the American Academy of Family Physicians:

Harry Ageloff, MD,* Racine
Paul J. Ambro, MD,* Kenosha
Henry S. Ashe, MD,* Woodruff
Merne W. Asplund, MD,* Bloomer
Hulburt W. Bardenwerper, MD,* Waterford
Charles R. Brillman, MD,* Milwaukee
Jeffrey J. Brook, Jr., MD,* Sturgeon Bay
Jack D. Brown, MD,* Sparta
E. Frank Castaldo, MD,* Laona
Benward L. Chapman, MD,* Milwaukee
Robert W. Cromer, MD,* Antigo
John A. Davies, Jr., MD,* Milwaukee
Lief W. Erickson, MD,* Burlington
Patrick J. Finucane, MD,* Eau Claire
Henry A. Fletcher, MD,* Milwaukee
Duane L. Flogstad, MD,* Shell Lake
K. Karl Ford, MD,* Amery
Ihor A. Galarnyk, MD,* Plain
R. S. Galgano, MD,* Delavan
Guy G. Giffen, MD,* Eau Claire
Frederick W. Gissal, MD,* Wisconsin Dells
John O. Grade, MD,* Elm Grove
June L. Grinney, MD,* Racine
Franz Gutowski, MD,* Plymouth
Wendell D. Hamlin, MD,* Mineral Point
Eugene S. Hartlaub, MD,* Janesville
Paul S. Haskins, MD,* River Falls
Wm. C. P. Hoffmann, MD,* Hartford
Everett W. Humke, MD, Redlands
Kenneth R. Humke, MD,* Chilton
Martin L. Janssen, MD,* Friendship
Emmet R. Killeen, MD,* Green Bay
George Kordiyak, MD,* Wausau
Edward O. Lukasek, MD,* Sparta
John A. Malone, MD,* Milwaukee
Michael G. Marra, MD,* Amery
J. C. McCullough, MD,* Fond du Lac
Norbert A. McGreane, MD,* Darlington
William R. McInnis, MD, Marion
Gerald B. Merline, MD,* De Pere
Michael J. Miech, MD,* Menomonie
Lee E. Miller, MD,* West Allis
Dale V. Moen, MD,* Shell Lake
Theodore J. Nereim, MD,* Mt. Horeb
Vincent W. Nordholm, MD,* Stoughton
Charles J. Picard, MD,* Superior
Joseph D. Postorino, MD,* Racine
Paul J. Purtell, MD,* Milwaukee
Esther L. Rau, MD,* Janesville
Raymond R. Richards, MD,* Eau Claire
Wilbur E. Rosenkranz, MD,* Mukwonago
Sam Salan, MD,* Waupaca
Anthony J. Sanfelippo, MD,* Milwaukee
Harry E. Schaefer, MD, Manitowoc
William J. Schibly, MD,* Green Bay
L. O. Simenstad, MD,* Osceola
R. E. Skupniewicz, MD,* Racine
Kenneth M. Smigielski, MD,* Milwaukee
Albert H. Stahmer, MD,* Wausau
Samuel J. Sweet, MD,* Milwaukee
George J. Twohig, MD,* Kiel
Louis B. Uszler, MD,* Milwaukee
George E. Wahl, MD,* Eau Claire
Karl E. Walter, MD,* Eau Claire
Arthur R. Weihe, MD,* Friendship
Louis W. Weisbrod, MD,* New Richmond
Warren H. Williamson, MD,* Racine
Erie W. Wits, MD,* Kewaunee
Raymond G. Yost, MD,* Manitowoc
Forrest E. Zantow, MD,* Oconto
Gibbs W. Zauft, MD,* Prairie du Sac

The degree of Fellow, established by the 1971 Congress of Delegates, is the Academy's avenue for recognizing outstanding member efforts in the area of continuing education. To qualify for this degree, a member must either have passed the certifying examination in Family Practice, administered by the American Board of Family Practice, or have completed 600 hours of Academy-approved continuing education since becoming an active member.

The 4,200 initiates, who were inducted as Charter Fellows, have met one or both of the above criteria. Their efforts typify the high standard of family medicine the Academy seeks to instill in all practicing family physicians, the inductees were told.

Five Wisconsin Clinics Receive AAMC Accreditation

Five Wisconsin clinics were among 37 clinics nationwide that were awarded the American Association of Medical Clinics' Certificate of Accreditation at the Association's Annual Meeting held September 6–10 in Atlanta, Ga.

They are: Beloit Clinic, SC, Beloit; Gundersen Clinic, La Crosse; Midelfort Clinic, Eau Claire; Monroe Clinic, Monroe; and Sheboygan Clinic, Sheboygan.

Accepting the certificates in behalf of the clinics were: Donald C. Burandt, MD, president, and Gerard F. Moore, assistant business manager of the Beloit Clinic; R. B. Rasmus, MD,* member of the Board of Directors of the Gundersen Clinic; Bruce C. Bayley, MD,* member of the Board of Directors of the Midelfort Clinic; James R. Stormont, MD,* chairman of the Executive Committee of the Monroe Clinic; and Edward G. Schott, MD,* president of the Sheboygan Clinic.

The American Association of Medical Clinics sponsors a wide variety of activities to promote improvement in the group medical practice mode of health care delivery. The Accreditation Program is one of the Association activities. Its primary objective is to "periodically . . . evaluate the conduct, performance, and quality of the medical care delivered by group practice clinics in order to certify and accredit them as qualified comprehensive medical and diagnostic centers."

Since the accreditation program began four years ago, 70 clinics have been accredited by the AAMC, including other clinics in Wisconsin.

Cardiovascular Disease Seminar Held in Wausau

About 100 physicians from around the state attended the daylong seminar, "Focus on Cardiovascular Disease," in mid-September in Wausau. This was the second seminar to be cosponsored by the Marathon County Medical Society and Employers Insurance of Wausau at the Employers' home office complex. Last year's subject was pediatrics.

Wisconsin Radiological Society Names Officers

Andrew B. Crummy, MD* of Madison was elected president of the Wisconsin Radiological Society at its annual meeting September 15–17 at the Pioneer Inn, Oshkosh. He succeeds Leslie E. Jones, MD* of Fond du Lac.

Other new officers are: MDs Robert F. Douglas*, Neenah, president-elect; John Swingle,* La Crosse, vice-president; and Marvin L. Hinke,* Marshfield, secretary-treasurer. Loren L. Thompson, MD* of Green Bay and I. Nik Nevin, MD* of Rhinelander were elected to the board of directors.

Robert G. Zach, MD* of Monroe was elected a councilor to the American College of Radiology and John R. McKenzie, MD* of Oshkosh and Robert C. Feulner, MD* of Waukesha were elected alternate councilors.

The main guest speaker at the meeting was Paul C. Kahn, MD, professor of radiology of Tufts University School of Medicine, New England Medical Center, Boston, Mass.

Wisconsin Society of Public Health Physicians

The Wisconsin Society of Public Health Physicians recently elected the following officers: president—Gabriel P. Ferrazzano, MD,* Racine; president-elect—H. Grant Skinner, MD,* Madison; and secretary—Josef Preizler, MD, Madison. On the Executive Committee are: MDs Preizler and Arthur L. Van Duser, Madison; and Lyle D. Franzen,* Waukesha.

PHYSICIAN BRIEFS . . .

Frederick Tavill, MD

. . . Fox Point, recently was named head of a new medical care program introduced by the Milwaukee County Medical Complex. He is coordinator of ambulatory care and will direct the new Downtown Medical and Health Services in the former county hospital building.

George M. Goza, Jr., MD*

. . . medical director of the Northern Pines Guidance Clinic, recently announced his resignation effective Oct. 1. Doctor Goza returned to the practice of his former specialty of internal medicine and cardiology and is associated with the Cumberland Clinic.

David Hilton, MD*

. . . Menomonie, recently was named a diplomate of the American Board of Family Practice.

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Dr. Farrington

Dr. Johnson

J. D. Farrington, MD*

. . . Minocqua, recently retired from active practice in orthopedic surgery but plans to "continue his quest to provide the very best emergency medical service possible for his fellow man." Known for his work in the emergency medical service field, Doctor Farrington has taken on many speaking engagements and will participate in meetings all over the United States in the coming months. He was honored recently at a testimonial dinner to which more than 500 friends attended. Todd Mallory, MD, medical director for Employers Insurance of Wausau, was the master of ceremonies.

Sture A. M. Johnson, MD*

. . . professor of dermatology at the University of Wisconsin–Madison Medical School, was the guest editor for the September 1972 issue of *Cutis*, a publication of the Yorke Medical Group devoted to cutaneous medicine for the practitioner.

The special issue was devoted to the University of Wisconsin and Wisconsin authors. Abstracts of some of these articles will be forthcoming in the *Wisconsin Medical Journal.*

Doctor Johnson had previously been reported as having retired from the UW–Madison Medical School. However, this report was incorrect. Doctor Johnson has relinquished his post as chairman of the Department of Dermatology, but he remains a professor in the department and continues to teach and serve private patients.

continued on page 50

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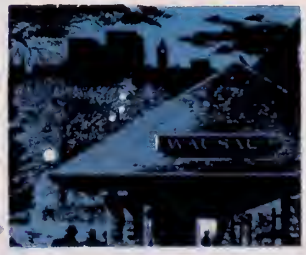


Employers Insurance of Wausau

MSS

Management Systems and Services

Doctor Johnson became professor and chairman of the Department of Dermatology in 1946. He is a member of the American Dermatological Association, a past vice-president of the Society of Investigative Dermatology, and a past president of the Wisconsin Dermatological Society. He also has served on two different occasions as a member of the Board of Directors of the American Academy of Dermatology. Doctor Johnson also was instrumental in the establishment of a section on Dermatology in the State Medical Society.

He is the author of many scientific articles dealing with experimental syphilis in animals, tryptophan metabolism, and inherited skin disorders, and has helped introduce and evaluate new drugs used in the treatment of various diseases.

Walter R. Sundstrom, MD*

. . . Madison rheumatologist, is serving as medical advisor to a series of free monthly discussions being conducted by the Southern District, Arthritis Foundation of Wisconsin, for parents of children between the ages of 3 and 16 who have juvenile rheumatoid arthritis. The first meeting was held October 5 at St. John's Lutheran Church in Madison. Discussions focus on unique problems common to parents of children with juvenile rheumatoid arthritis.

Stephen C. Copps, MD*

. . . La Crosse, pediatrician at the Gundersen Clinic, Ltd., recently was elected to membership in the International Teratology Society. Doctor Copps is the eighth man in Wisconsin to join the society.

Young Il Kim, MD

. . . recently became associated with the medical staff of the Dodgeville Clinic. Doctor Kim graduated from Pusan University, Korea, in 1965 and served his internship at Brooklyn's Methodist hospital. Prior to joining the staff at the Clinic, he was a resident surgeon in Philadelphia.

Wisconsin Neurological Society Fall Meeting

The Fall Meeting of the Wisconsin Neurological Society was held at the Kahler Motel in Wisconsin Dells on November 10 and 11. The program included a get-together party Friday evening, November 10. Saturday, November 11, the scientific session included the following speakers and their topics: Dr. H. E. Booker, *Dilantin. Binding and Intoxication;* Drs. E. J. Bravo–Fernandez and E. K. Mladinich, *Congenital Universal Muscle Hypoplasia;* special guest lecturer, Dr. B. J. Alpers; Drs. A. W. Dudley, T. Chuprevich, P. Sehraeder, E. Sajor, *Central Pontine Myelinolysis; a vascular syndrome?;* Drs. F. M. Forster* and R. F. Daly, *Reading Epilepsy in Identical Twins;* Dr. T. F. Vigorito, *Some Clinical Characteristics of Patients with Clinical Seizures and Normal EEG;* Drs. G. G. Celesia* and W. M. Wanamaker, *Psychiatric Disturbances in Parkinson's Disease;* business meeting; Wisconsin Neurological Society banquet.

American College of Surgeons Inducts Fellows

Twenty-three Wisconsin physicians were among the approximately 1,527 initiates who were inducted as new Fellows of the American College of Surgeons during its annual Clinical Congress in early October in San Francisco.

They are: MDs Jeffrey L. Warren,* Appleton; Mayer Katz,* Beloit; Val D. Adamski,* De Pere; David L. Nelson,* Fond du Lac; Louis C. Bernhardt,* Timothy J. Donovan,* and Willis G. McMillan,* Madison; Schaul Sarmicanic,* Marshfield; Thomas M. Aaberg,* Charles W. Bourne,* Stuart W. Fine,* Thomas J. Flatley,* Ruedi P. Gingrass,* Frank P. Goldstein,* Andrew A. Pandazi,* Dean P. Spyres,* and Alfred J. Tector, Jr.,* Milwaukee; Johan A. Mathison,* Oshkosh; Clarence A. Klasinski,* Stevens Point; Edward J. Buerger,* Waukesha; and John P. Hartwick,* Alexander J. MacGillis,* and William E. Martens,* Wauwatosa.

MCW Receives Student Aid Grant

The Medical College of Wisconsin (MCW) recently announced receipt of a $69,127 grant from the Robert Wood Johnson Foundation, Princeton, N.J., under the Foundation's nationwide student aid program to increase the number of future doctors likely to enter practice in medically underserved areas.

The grant provides support over the next four academic years for scholarships and loan awards to women students, students from rural areas (home county with a population of 50,000 or less) and those from the country's black, Indian, Mexican–American and U. S. mainland and Puerto Rican populations.

The grant is part of a $10 million program to assist students in these categories in all the nation's 108 schools of medicine and 7 schools of osteopathy. They are being administered by the Association of American Medical Colleges under guidelines established by the Foundation.

Downtown Medical and Health Services Center

Over 900 persons were reported to have walked into the Downtown Medical and Health Services Center during its first two weeks of operation in the old Milwaukee County Emergency Hospital in Milwaukee's inner city area. This outpatient emergency clinic started August 30 with the primary aim of serving the inner city community where such service is not otherwise provided. Frederick Tavill, MD, who heads the new service, has assigned Marc Erickson, MD and Barbara A. Smith, RN as staff physician and nurse in charge.

Wisconsin Society of Internal Medicine Elects

New officers elected at the Wisconsin Society of Internal Medicine meeting September 15–16 at the Holiday Inn, La Crosse, are: Robert F. Madden, MD,* Milwaukee, president; Joseph B. Grace, MD,* Green Bay, president-elect; and George E. Owen, MD,* Eau Claire, secretary-treasurer.

Society of Nuclear Medicine Central Chapter Met

The direction of developing techniques employing radionuclides for cardiovascular diagnosis was discussed at the fall meeting of the Society of Nuclear Medicine, Central Chapter, November 10–11, at Milwaukee's Marc Plaza Hotel. The one and a half day program was offered through the Office of Continuing Medical Education, The Medical College of Wisconsin.

Doctor Oglesby Paul, nationally known cardiologist from Northwestern University Medical School, discussed present diagnostic techniques and future needs. Other topics included myocardial imaging, radionuclide cardioangiography, coronary microcirculation mapping, and deep vein thrombosis detection.

Richard A. Holmes, MD,* associate professor of medicine, MCW, and director of nuclear medicine at Milwaukee County General Hospital, was assisted in program planning by Edward A. Silverstein, PhD, assistant professor of radiology, MCW, and Ian B. Tyson, MD,* associate professor of medicine, University of Wisconsin–Madison Medical Center.

New Hospital at Ashland Dedicated

In early September a dedication and "open house" event preceded the opening of the new Memorial Center at Ashland later that month. The $4,800,000 building includes 101 beds; three operating rooms; x-ray, laboratory, and outpatient sections with expansion possibilities.

MD members of the Memorial Medical Center Board are: Arlyn A. Koeller,* and Kenneth A. Morrow, Ashland.

Wisconsin Society of Ob–Gyn Officers

Herbert Sandmire, MD* of Green Bay was elected president of the Wisconsin Society of Obstetricians and Gynecologists at its annual meeting October 6–7 at the Pioneer Inn in Oshkosh. Secretary is William J. O'Leary, MD* of La Crosse.

Wisconsin Society of Anesthesiologists Elect

Frederick J. Carpenter, MD* of Milwaukee was elected president of the Wisconsin Society of Anesthesiologists at its annual meeting September 23–24 at the Pioneer Inn, Oshkosh. Ruth A. Stoerker, MD* of Madison was reelected secretary.

Racine A-Center Awarded Community Service Grant

The White House Special Action Office for Drug Abuse Prevention and the National Institute of Mental Health recently announced that The A-Center of Racine was granted funds totalling $484,215 to provide treatment and rehabilitation services for narcotic addicts and other drug abusers in the community.

West Allis Memorial Hospital Opens New Floor

A new seventh floor facility was opened recently by the West Allis Memorial Hospital. This was the first major expansion move since the hospital opened 11 years ago. The new facility adds 51 beds for a total hospital capacity of 296 beds. Included in this floor are beds for coronary care, post-coronary care, intensive care, and general medical and surgical care.

Larry L. Heller, MD

. . . Fond du Lac, recently joined the medical staff of the Sharpe Clinic, S.C. He graduated from Ohio State Medical School and completed his residency at the Riverside Methodist Hospital, Columbus, Ohio. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1972

1 Executive Board, American Association of Medical Assistants—Wisconsin Society
3 Madison Urological Society
3 Dane County Medical Society Board of Trustees
4 SMS Committee on Economic Medicine
4 SMS Commission on Safe Transportation
4 SMS Division on Alcoholism and Addiction
5 Board of Directors, Wisconsin Health Care Review, Inc.
5 SMS Ad Hoc Committee on Districting
6 Preceptors and Faculty, University of Wisconsin Medical School
11 Cooperative Assembly on Health Screening of Young Children
11 SMS Commission on State Departments
12 Permanent Commission on the Museum of Medical Progress
13 Board of Trustees, SMS Realty Corporation
14 Editorial Board, Wisconsin Medical Journal (Madison Club)
18 Madison Anesthesiology Society
19 Executive Committee, SMS Commission on Medical Care Plans
20 Steering Committee and Task Force, Wisconsin Emergency Medical Service Program
25 Executive Committee of SMS Council and SMS Commission on Public Policy
26 SMS Division on Chest Diseases
31 Board of Directors, Madison Chapter of the American Management Society

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

American Association of Medical Assistants, Inc.

Wisconsin Society

A QUARTERLY COMMUNICATION TO PHYSICIANS NOVEMBER 1972

It has been noted by this writer, today, many articles are written in the vein of a personal letter; with this in mind,

DEAR DOCTOR:

The essentials of an accredited educational program for Medical Assistants received unanimous approval of the American Medical Association's House of Delegates at the New York meeting in July 1969. That achievement marked the beginning of approved schools in medical assisting.

Established by the AMA's Council on Medical Education in collaboration with the American Association of Medical Assistants, the essentials served as a guide for the development of effective educational programs for Medical Assistants.

Accredited Educational Program

The essentials recommended that the two-year program be broad in scope "providing a basic understanding of medicine, some acquaintance with clinical work, familiarity with medical ethics and law, and a comprehensive knowledge of how to operate a doctor's office efficiently and successfully". It suggested the training should aim at developing adeptness in promoting good relations with patients and the public at large, and a capability for calm and reasoned judgment in meeting emergencies.

The basic curriculum was based on the AAMA certification study outline. Topics included anatomy and physiology; medical terminology; medical law, ethics, and economics; psychology; administrative and clinical procedures; and a basic knowledge of the purpose and techninque of laboratory procedures commonly performed in the physician's office. A review and rotation sequence of practical experience in offices of qualified physicians or in accredited hospitals selected by the educational institutions was also recommended.

Doctor, are you aware a "second" step has been taken toward assuring quality education for medical assistants? Standards have been revised to allow greater curriculum flexibility. Principal changes include the development of a basic one-year curriculum and allowance for medical specialty courses within the existing two-year program.

In addition, the curriculum may be established in vocational-technical schools, proprietary educational institutions, and military-based schools as well as junior, community and senior colleges. Adequate clinical facilities are one of the requirements for approval.

The revised standards of "essentials" supplement the original two-year medical assisting curriculum developed jointly by the American Medical Association (AMA) and the American Association of Medical Assistants (AAMA) three years ago. With these changes, AAMA can make available a single package of standards. The one-year curriculum offers the fundamentals of medical assisting for students who must limit their advanced education. It provides a basic knowledge of anatomy and physiology, medical terminology, medical law and ethics, psychology, bookkeeping, insurance claims and clinical procedures. This program leads to a one-year medical assisting certificate.

The two-year program leads to an Associate degree and offers basic and advanced medical assisting courses, including humanities and social sciences or electives in a particular medical specialty.

Doctor, although, advanced education for medical assistants is relatively new, more and more physicians are requiring it. Years ago a doctor could train his medical assistant on the job. Today, the increasing demand for health care has made it necessary for him to look for employees already qualified.

Most medical assistants are employed in a physician's office or other medical facility under such job titles as medical assistant, medical secretary, receptionist, bookkeeper or medical office manager. They are the direct link between the physician and his patients, his professional associates, and the suppliers of equipment and medications.

Thank you, Doctor, for your continuing cooperation, we look to educational opportunities for the medical assistant and our further aims and purposes.

For further information contact the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701.

Sincerely,

Your Medical Assistant □

Bill Schweers, claims manager, sees the correct information on the CRT just two seconds after the proper button is pushed.

you help us . . .
medical assistants
. . . and we help you

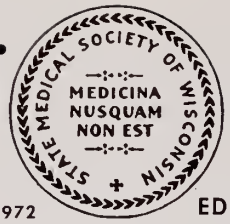
We appreciate what you are doing to help us. And to prove it, this is what we have done. We have installed the Medex Inquiry System to record permanently the subscriber information that you give us. Our computer does the storing. When you have a question just give us the subscriber's number, then we push the proper button and have your answer in two seconds. The answer comes onto the screen of the CRT (cathode ray terminal shown here) and our representative tells it to you. No more putting you on "hold" or calling back later. You have the information you need and our gal is ready for another call. We're quite a team in providing health care, planned by people who CARE for people.

Watch the *Wisconsin Medical Journal* for a special insert for medical assistants.

WPS

WISCONSIN PHYSICIANS SERVICE
330 East Lakeside St. • Madison, Wis. • 53701

SECTION



OPHTHALMOLOGY

NOVEMBER 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

RESIDENTS COMPLETE TRAINING

Five ophthalmology residents completed their training at the Medical College of Wisconsin in July 1972. They have now located in the following cities: MDs Jorge N. Chin, Milwaukee; Thomas J. Cesarz, Milwaukee; James D. Furnary, Fremont, Calif.; Peter J. Groessl, Green Bay; and Robert H. Poirier, San Antonio, Tex.

NEW OPHTHALMOLOGISTS IN WISCONSIN

Paul Rice, MD recently became associated with W. E. Scheunemann, MD, West Bend, in the practice of ophthalmology. A graduate of the University of Illinois College of Medicine, he served his internship at the University of Tennessee in Memphis and his residency at the University of Illinois Eye and Ear Infirmary in Chicago.

Karl Aldinger, MD recently became associated with the Rice Clinic in the Department of Ophthalmology in Stevens Point. He graduated from the University of Iowa Medical School and completed his internship at Good Samaritan Hospital, Portland, Ore. He served in the United States Navy for two years and took his residency at the University of Texas Southwestern Medical School in Dallas, Tex.

Steven J. Herman, MD has become the sixth ophthalmologist to join the Eye Clinic of Wausau, SC. Doctor Herman attended the University of Illinois Medical School and served his internship at the Cook County Hospital, Chicago. After two years in the Public Health Service, Doctor Herman completed the Ophthalmic Basic Science course at the Harvard Postgraduate Medical School in Boston. Following this course he took his ophthalmology residency at the University of Illinois Eye and Ear Infirmary, Chicago. Upon completion of his residency an additional six months fellowship was taken in retinal surgery under the direction of MDs Morton F. Goldberg, Charles Vygantas, and Joel Kaplan.

OPHTHALMOLOGY CLINIC OPENS IN RHINELANDER

The Eye Clinic of Wausau, SC has opened a satellite office in Rhinelander. It is located at 14 East Davenport Street and includes two complete examining rooms, a screening room, and optical dispensing area. The office will have four-day-a-week coverage by the six ophthalmologists of the Eye Clinic of Wausau, SC. They will rotate to the Rhinelander office for a week at a time. The office opened August 7 and is staffed with three full-time personnel.

TO STUDY NEW CATARACT REMOVAL PROCEDURE

The American Academy of Ophthalmology and Otolaryngology, at its annual business meeting in Dallas September 28, approved unanimously the following resolution:

> The extensive lay publicity given to the use of the ultrasound needle for the removal of cataracts was brought to the attention of the Council.
>
> It was the opinion of the Council that scientific evidence has not been published in the medical literature to prove that this procedure is as safe or as effective as the methods of cataract extraction now used. The Council was quite concerned about the extensive lay publicity given the ultrasonic techniques before any long-term scientific value was determined.
>
> An ad hoc committee of the Council will be appointed to gather information and data on the safety, effectiveness, and value of this technique. A symposium on ultrasonic removal of cataracts will be held at the Academy's 1973 annual meeting in Dallas.

O–O DOCTORS SUCCUMB

The September issue of the *Wisconsin Medical Journal* reported the deaths of Thomas B. McNamara, MD of Stone Lake, an ophthalmologist on June 20; and Clemens R. Kwapy, MD of Wauwatosa, an otolaryngologist, on June 16.

CURRENT CONCEPTS IN OPHTHALMOLOGY

The Cleveland Clinic Educational Foundation will present a postgraduate course in Continuing Medical Education (accredited by AMA) on "Current Concepts in Ophthalmology," December 6 and 7.

Guest speakers: Richard Forster, MD, University of Miami, Fla.; Paul Henkind, MD of Montefiore Hospital and Medical Center, Albert Einstein College of Medicine, New York; Robert Machemer, MD, of Bascom Palmer Eye Institute, Miami, Fla.; and Clinton D. McCord, Jr., MD of Emory University, Atlanta, Ga.

Registration fee: $60. Further info: Cleveland Clinic Educational Foundation, 9500 Euclid Ave., Cleveland, Ohio 44106.

DATES TO REMEMBER

May 13–18, 1973: Sixth International Course of Ophthalmology, Barcelona, Spain. Registration opens Oct. 1, 1972. Fees: $150 until Jan. 31, 1973; thereafter, $200. Contact: Instituto Barraquer, Laforja, 88. Barcelona-6 (Espana). □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF OCTOBER 13, 1972

NEW MEMBERS

Angel, John J., 8700 West Wisconsin Ave., Milwaukee 53226
Atkins, F. Eliska, 1300 University Ave., Madison 53706
Basque, George J., 2900 West Oklahoma Ave., Milwaukee 53215
Bingham, William F., 1836 South Ave., La Crosse 54601
Bincer, Wanda L., 5534 Medical Circle, Madison 53711
Bodner, Aaron C., 3975 North 68th St., Milwaukee 53216
Bogdanowicz, Wojciech M., 1313 Fish Hatchery Rd., Madison 53715
Bollinger, John T., 250 Buffalo St., Mondovi 54755
Calado, Brigido C., 621 East Main St., Watertown 53094
Caldwell, Richard B., 3125 Todd Drive, Madison 53713
Christian, George H., 10 Quarterdeck Dr., Madison 53705
Dais, Charles F., 1201 South Monroe, Green Bay 54301
Faylona, Renato T., South Vine St., Wisconsin Dells 53965
Frase, Louis H., Route #6, Harless Rd., Eau Claire 54701
Fry, Gerald L., 715 South Barstow St., Eau Claire 54701
Hansen, DuWayne A., 621 West High St., Seymour 54165
Happe, Philip J., 733 West Clairemont Ave., Eau Claire 54701
Horkheimer, Ronald W., 5900 South Lake Dr., Cudahy 53110
Hur, Su-Ryong, 8700 West Wisconsin Ave., Milwaukee 53226
Jiongco, Edgardo C., 1115 Talcott Ave., Fort Atkinson 53538
Johnson, Daniel F., 733 West Clairemont Ave., Eau Claire 54701
King, Douglas, 5000 West Chambers St., Milwaukee 53210
Lahiri, Prasanta K., 835 North 23rd St., Milwaukee 53233
Layde, John P., 733 West Clairemont Ave., Eau Claire 54701
Lo, Romeo C., 1255 North 22nd St., Milwaukee 53205
Manz, Carl W., 733 West Clairemont Ave., Eau Claire 54701
McCabe, Edward B., 30 South Henry St., Madison 53703
McKichan, John M., 1370 North Water St., Platteville 53818
Merritt, James W., 733 West Clairemont Ave., Eau Claire 54701
Mikkelson, Michael K., 716 East 2nd St., Merrill 54432
Milbrath, John R., 8700 West Wisconsin Ave., Milwaukee 53226
Oliphant, William W., Jr., 1370 North Water St., Platteville 53818
O'Mara, Michael G., 888 Thackeray Trail, Oconomowoc 53066
Robinson, James E., 1255 North 22nd St., Milwaukee 53205
Rogers, Jonathan W., 733 West Clairemont Ave., Eau Claire 54701
Sablay, Nonito M., P. O. Box 1378, Fond du Lac 54935
Schuh, Ruth, 907 Clyman St., Watertown 53094
Shafi, Mohammad, 948 North 12th St., Milwaukee 53233
Simani, Rahmatollah, Friendship 53934
Stewart, Edward T., 8700 West Wisconsin Ave., Milwaukee 53226
Stine, Harold E., P. O. Box 1221, Green Bay 54305
Vogel, Edward G., 1551 Dousman St., Green Bay 54303
Weinhold, Frank M., III, 3072 Bay View Drive, Green Bay 54301
Yerex, Joyce A., 3321 North Maryland Ave., Milwaukee 53211

CHANGE OF ADDRESS

Ageloff, Harry, 312—7th St., Racine 53403
Andrews, Walter C., 420 West Earle Dr., Phoenix, Ariz. 85013
Arcilla, Senen S., 230 Elizabeth St., Watertown 53094
Arsenovic, Alexandar, VA Center, Martinsburg, West Va. 25401
Babbitt, Lon D., P. O. Box 1054, Green Bay 54303
Baker, Robert M., 3420 Viburnum Dr., Madison 53705
Blanchard, Porter B., 705 North 3rd Ave., Cedarburg 53012
Bookhamer, James W., 11910 West Mill Rd., #5, Milwaukee 53225
Brady, John J., 430 Pinellas St., Clearwater, Fla. 33516
Brown, Dwight H., 17000 West North Ave., Brookfield 53005
Burg, Richard M., 430 Court St., Utica, New York 13502
Charnecki, George, 2219 Taylor Court, Janesville 53545
Church, Ruth E., 435 Starin Rd., Apt. 102C, Whitewater 53190
Clarke, B. Earl, 2019 East Shorewood Blvd., Milwaukee 53211
Cohen, Donald J., 8653 North Port Washington Rd., Milwaukee 53217
Collins, Richard A., 175 College St., Battle Creek, Mich. 49017
Conley, Harold L., Route #3, Box 3-B, Wisconsin Dells 53965
DeGroot, Henry E., 3801 Monarch Dr., Racine 53406
Epstein, Ely, 8653 North Port Washington Rd., Milwaukee 53217
Farnsworth, Richard W., 301 North Ocean Blvd., Apt. 612, Pompano Beach, Fla. 33062
Foerster, Frederick E., P. O. Box 1865, Santa Fe, New Mexico 87501
Fralich, Joseph C., 825 Orchard St., Racine 53405
Gericke, Julius T., Jr., 258 West Lexington Blvd., Eau Claire 54701
Grossmann, Erwin E., 115 East Silver Spring Dr., Milwaukee 53217
Gruesen, Robert A., 130 East Walnut St., Room 205, Green Bay 54301
Gute, Daniel B., 6300 North Port Washington Rd., Milwaukee 53217
Halleck, Seymour L., University of North Carolina, Department of Psychiatry, Chapel Hill, N. C. 27514
Hart, Loren E., Jr., P. O. Box 1054, Green Bay 54303
Hirsch, Samuel R., 3615 West Oklahoma Ave., Milwaukee 53215
Hirschboeck, John S., 735 North 5th St., Milwaukee 53203
Hull, David S., 1260 Greenway Terr., Apt. 4, Brookfield 53005
Hull, Stephen B., Winnebago State Hospital, Winnebago 54985
James, Richard L., 3604 East College Ave., Cudahy 53110
Jiroch, John T., Route #2, Box 24, Manitowoc 54220
Jones, William D., 704 South Webster Ave., Green Bay 54301
Joseph, Leo G., 925 South 11th St., La Crosse 54601
Kauffman, Herbert M., 14405 Juneau Blvd., Elm Grove 53122
Kolmeier, Karl H., 3801 Monarch Dr., Racine 53406
Lie, Tjing, H., 6300 North Port Washington Rd., Milwaukee 53217
Lontok, Emilio M., 3245 Town Crier Court, Brookfield 53005
Lucas, Paul M., 733 North Van Buren, Milwaukee 53202
Majewski, Joseph T., VA Hospital, Tomah 54660
McLean, Zarah G. H., 1255 North 22nd St., Milwaukee 53205
Meade, Robert C., 13000 North 30th St., Tampa, Fla. 33612
Miller, David, Newton, Iowa 50208
Milliken, Lyle D., Jr., 6215—10th Ave., Kenosha 53140
Mobarek, Yousef S., 5511 West National Ave., Apt. 123, Milwaukee 53214
Nemec, George, Jr., P. O. Box 28, Cambridge 53523
Olsen, Leonard C. J., 1445 Milwaukee St., Delafield 53018
Palisoc, Jose M., 8210 Fielding Lane, Greendale 53129
Pecina, Ivo, 2420 West Applewood Lane, Milwaukee 53209
Peck, Donald D., P. O. Box O, Omro 54963
Rank, Philip P., 3107 Stevens St., Madison 54705
Reynaldo, Primitivo, 6300 North Port Washington Rd., Milwaukee 53217
Rosenbaum, Francis F., 3321 North Maryland Ave., Milwaukee 53211
Ruch, Donald M., 1848 Marine Plaza, Milwaukee 53202
Sarkarati, Ebrahim, 5666 East State St., Rockford, Ill. 61101

SOCIETY RECORDS . . .

Schneider, William F., 704 South Webster Ave., Green Bay 54301
Speckhard, Mark E., 1304 Pine Ave., Loveland, Colo. 80537
Stewart, Richard D., 18525 Chevy Chase Dr., Brookfield 53005
Stram, Thomas W., 1507 North Shawano Dr., Marshfield 54449
Strickland, Samuel A., 403 Hill St., Summersville, West Va. 26651
Taskin, Edward H., 6829 West Capital Dr., Milwaukee 53216
Tierney, Edward F., 916 Silver Lake Dr., Portage 53901
Trangsrud, Howard A., P. O. Box 4133, Milwaukee 53210
Walker, Thomas F., 211 South Monroe, Green Bay 54301
Way, Anthony B., 3311—41st St., Lubbock, Tex. 79413
Way, Barbara H., 3311—41st St., Lubbock, Tex. 79413
Whiteway, Robert E., 134 North Leonard St., West Salem 54669
Wong, James R. P., 903 South Quincy, Green Bay 54301
Wyman, John F., P. O. Box 94, Cedar Mountain, N. C. 28718
Young, Helen C., 5810 South 41st St., Milwaukee 53221
Young, Michael M. C., P. O. Box 513, Elm Grove 53122

DEATHS

Jenkinson, Edward L., nonmember, July 30, 1972
Erickson, Milo T., Iowa County, Aug. 7, 1972
Miller, Evan A., nonmember, Aug. 9, 1972
Lange, Ramon L., Milwaukee County, Aug. 20, 1972
Gilbertsen, Cecil R., Rock County, Sept. 5, 1972
Inman, Richard F., Columbia–Marquette–Adams County, Sept. 5, 1972
Langjahr, Arno R., Milwaukee County, Sept. 7, 1972
Natenshon, Adolph L., Milwaukee County, Sept. 7, 1972
Coon, Wallace W., Walworth County, Sept. 14, 1972
Wolters, Herbert F., nonmember, Oct. 1, 1972 □

Wisconsin Students: Short of Cash?

The State Medical Society's Charitable, Educational and Scientific Foundation (CESF) has money available for long term, low interest loans which are interest-free until after medical school is completed. The loans are designed to "fill the gap" for students whose own resources aren't quite enough.

CESF funds are limited, so the loans can only be given to Wisconsin residents enrolled in Wisconsin medical schools—The University of Wisconsin Medical School in Madison and The Medical College of Wisconsin in Milwaukee. Deans of the medical schools must approve the applications before loans can be granted.

CESF loans are generally under $1,000 a year for a total of three years. Application forms and complete information are available at the CESF office, 330 East Lakeside Street, Madison.

Funds for these loans have been given to the Foundation to administer according to the wishes of the donors. Several of the loan programs have been set up by county medical societies for students from within that county. Physicians individually have established loan programs and others have contributed significantly to the general student loan program. Industry, too, has contributed substantially.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

Phone 567–5535
MILWAUKEE OFFICE—367–3172

ROGERS MEMORIAL HOSPITAL

A NEUROPSYCHIATRIC HOSPITAL — OCONOMOWOC, WISCONSIN

A neuropsychiatric hospital for the intensive medical treatment of neurological and psychiatric disorders. Complete facilities for Occupational and Recreational Therapy under the direction of trained personnel. A nonprofit, nonstock, voluntary hospital.

MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1972 WISCONSIN

Dec. 14: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

1972 NEIGHBORING STATES

Dec. 1: Cardiac and Respiratory Disease Conference, Medical Alumni Auditorium, University of Iowa campus, Iowa City. Info: Director, Office of Medical Education, The University of Iowa, Iowa City, Ia. 52240.

Dec. 6–7: Postgraduate conference on obstetrics and gynecology. Iowa Memorial Union, University of Iowa. Info: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Ia. 52240.

Dec. 8–9: New Directions in Sports Medicine Symposium, Univ of Iowa, Iowa City.

1972 OTHERS

Dec. 2–7: Thirty-First Annual Meeting of the American Academy of Dermatology, Americana Hotel, Bal Harbour, Fla. Info: Frederick A. J. Kingery, MD, 2250 Northwest Flanders St., Portland, Ore. 97210.

Dec. 8: Geometric Total Knee Arthroplasty, Cleveland Clinic Educational Foundation Continuing Medical Education course accredited by the AMA, at Bunts Auditorium of the Education Building, 9500 Euclid Ave., Cleveland, Ohio 44106. Registration fee: $30.

1973 WISCONSIN

Jan. 17: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Feb. 15: State Medical Society In-Depth Teaching Program, Madison General Hospital, Madison.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Apr. 11: Family Practice Conference, Neenah.

Apr. 12: Family Practice Conference, Wausau.

Apr. 18: Family Practice Conference, Eau Claire.

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May 9: Family Practice Conference, Neenah.

May 10: Family Practice Conference, Wausau.

May 16: Family Practice Conference, Eau Claire.

1973 NEIGHBORING STATES

Feb. 7–9: Nuclear Medicine Conference, Hackley Hospital and the Central Chapter of the Society of Nuclear Medicine, Petoskey, Mich. Info: James C. Carlson, MS, Radiological Physics, Hackley Hospital, 1700 Clinton St., Muskegon, Mich.

Mar. 5–10: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, Chicago. 1855 West Taylor St., Chicago, Ill. 60612.

Mar. 26–29: Continuing education course in Neurotology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, 1855 West Taylor St., Chicago, Ill. 60612.

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Feb. 7–9: Twenty-Fifth Annual Meeting American Academy of Occupational Medicine, Royal Orleans Hotel, New Orleans, La. Info: James M. MacMillan, MD, Medical Director, Reynolds Metals Co., 6601 W. Broad St., Richmond, Va. 23218.

Feb. 21–24: Surgery of the Hand, University of Colorado School of Medicine, Office of Continuing Medical Education, 4200 East Ninth Ave., Denver, Colo. 80220.

Feb. 25–Mar. 3: *Continuing Education for Excellence in Medicine and Surgery.* Annual Meeting of the American Society of Contemporary Medicine and Surgery. Fountainbleau Hotel, Miami Beach, Fla. Info: Miss Virginia Kendall, 30 N. Michigan Ave., Rm. 1629, Chicago, Ill. 60602.

Mar. 10–11: Provocative Allergy Course, Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. Info: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609.

Mar. 15–16: 22nd Annual Postgraduate Course in Pediatrics of The University of Texas Medical Branch, Galveston, Tex. Info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Tex Medical Branch, Galveston, Tex. 77550.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

* * *

Course in Laryngology and Bronchoesophagology.

The Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, will conduct a continuing education course in Laryngology and Bronchoesophagology March 5 to 10, 1973.

The course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, MD. It will be held largely at the Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals.

Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested physicians will please write directly to the Department of Otolaryngology, Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, Ill. 60612.

MEDICAL MEETINGS . . .

Nuclear Medicine Conference—of interest to the surgeon, internist, general practitioner, and pediatrician. Sponsored by the Hackley Hospital and the Central Chapter of the Society of Nuclear Medicine, in Petoskey, Mich., Feb. 7–9, 1973.

Conference is unique in the sense that the clinical session is not a conference for those experienced in directing a nuclear medicine department, but is intended to show the surgeon, internist, general practitioner, and pediatrician how nuclear medicine procedures can serve him in establishing a diagnosis.

Faculty: Walter DiGiulio, MD, Director, Nuclear Medicine Dept, St. John's Hosp, Detroit. Howard Dworkin, MD, Director, Nuclear Medicine Dept, William Beaumont Hosp, Detroit. Ernest Fordham, MD, Chairman, Dept of Nuclear Medicine, Presbyterian–St. Lukes' Hosp, Chicago, Ill.

Alexander Gottschalk, MD, Director, Argonne Cancer Research Hosp, Chicago, Ill. Richard Holmes, MD, Director of Nuclear Medicine Dept, Milwaukee County General Hosp, Milwaukee. Merle Lokin, MD, PhD, Director, Div of Nuclear Medicine, U of Minnesota Hosp, Minneapolis. Philip Ruetz, MD, Director, Nuclear Medicine Dept, St. Mary's Hosp, Milwaukee.

Registration fee not yet established, but expected to be in range of $35 to $45. Info: James C. Carlson, MS, Radiological Physics, Hackley Hospital, 1700 Clinton St., Muskegon, Mich.

Continuing Education for Excellence in Medicine and Surgery will be the theme of the 1973 Annual Meeting of the American Society of Contemporary Medicine and Surgery being held from February 25 to March 3 at the Fontainebleau Hotel, Miami Beach, Florida. The president of the Society is Dr. Michael DeBakey.

Emphasis will be made on Contemporary Surgical Procedures in Diseases of the Cardiovascular System, Proctology, Gynecology, Urology, Otolaryngology, Orthopedics, Gastroentology, Reconstruction, and Esthetic Surgery.

The Council on Education of the American Medical Association has accredited the courses of the American Society of Contemporary Medicine and Surgery. A certificate will be awarded to all enrollees as evidence of participation. More and more states demand evidence from physicians of Continuing Education.

Admission: Members—$50.00. Nonmembers—$125.00. (Admission fees refundable to Feb. 1, 1973). Check payable to: Am. Society of Contemp. Medicine and Surgery.

For further information write: Miss Virginia Kendall, 30 N. Michigan Avenue, Rm. 1629, Chicago, Ill. 60602.

Course in Neurotology, March 26 through 29, 1973.

The Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, will conduct a continuing education course in Neurotology March 26 through 29, 1973.

This four-day intensive course will offer a didactic and practical review of clinical neurotology under the direction of Nicholas Torok, MD.

It will be held at the Eye and Ear Infirmary and will include basic vestibular physiology and pathophysiology, commonly used testing methods applied in functional examination of the vestibular organ.

In addition, various forms of caloric testing procedures will be demonstrated using nystagmography, reading and evaluation of the test results, particularly the nystagmogram, and correlation with audiometric and neurologic findings, final neurotological diagnosis, management and treatment. Patients will be tested by participants and the history, symptoms and test results will be discussed in informal conferences.

Enrollment is limited to twelve. For application forms write to the Department of Otolaryngology, 1855 West Taylor Street, Chicago, Ill. 60612.

Two-day postgraduate conference on obstetrics and gynecology will be held at Iowa Memorial Union on the University of Iowa campus Wednesday and Thursday, December 6 and 7, following a reception Tuesday evening, December 5.

Among lecture topics on Wednesday will be "Unwarranted Preoperative Fear of Death," "Current Concepts in the Management of Female Urinary Incontinence," "Amniocentesis," "Fathers in the Delivery Room," and "Contemporary Sexual Problems of Women."

Thursday's lectures will include discussions of how the family planning nurse should be trained and used, pitfalls in the management of gynecological malignancies, central venous monitoring in obstetrics and gynecology, and intrauterine assessment of fetal lung maturity. Consultation with the experts on individual case problems will be offered.

Guest faculty members for the conference will be Drs. Leo J. Dunn, Medical College of Virginia, Richmond; James C. Warren, Washington University School of Medicine, St. Louis; R. Clay Burchell, Hartford Hospital, Connecticut; and Richard M. Moore, President, Iowa Obstetrical and Gynecological Society, Des Moines.

For registration information, write: Director, Office of Medical Education, Office of the Dean, The University of Iowa, Iowa City, Iowa 52240.

REGISTRATION FORM

1972–1973 In-Depth Teaching Programs

Coordinated by the State Medical Society of Wisconsin

PLEASE CHECK the programs you plan to attend ($30 for *all four*; $8 for *each program less than four*. Enclose your check for proper amount payable to:

Charitable, Educational and Scientific Foundation
P. O. Box 1109, Madison, Wisconsin 53701

PLEASE CHECK SESSIONS YOU WISH TO ATTEND

St. Mary's Hospital

☐ Wed., Nov. 15, 1972
☐ Thurs., Dec. 14, 1972
☐ Wed., Jan. 17, 1973

Madison General Hospital

☐ Thurs., Feb. 15, 1973
Registration at 9:30 a.m. on all dates

You will be assigned the topic you have selected on one of the above dates. Your schedule of topics and dates will be sent to you as soon as it has been completed.

MORNING WORKSHOP TOPICS

Write "1–2–3–4" in Order of Your Preference

_____ Respiratory Emergencies
_____ Dr. Blue, Blue-cart, Code 99, or whatever you call it
_____ Clinical Cardiology
_____ Rheumatology
_____ Renal Disease
_____ Quality of Care—Appraisal Workshop
_____ Proctological Problems
_____ Pathology for the Practitioner
_____ Urological Problems

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(Please Print)

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(Street) (City) (Zip Code)

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(area code) (number)

1972–1973 In-Depth Teaching Programs

The forthcoming series of In-Depth Teaching Programs

THE EFFECTS OF MULTIPLE INJURIES

are provided by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin, in cooperation with the University of Wisconsin Medical School, St. Marys Hospital Medical Center, and Madison General Hospital.

Objectives of this year's lecture series is to explore in depth the systemic effects of multiple and massive injuries. Course is designed for physicians maintaining primary care responsibility for patients.

ST MARYS HOSPITAL

Wednesday, Nov. 15, 1972
Thursday, Dec. 14, 1972
Wednesday, Jan. 17, 1973

MADISON GENERAL HOSPITAL

Thursday, Feb. 15, 1973
Registration at 9:30 a.m.

Morning Workshop Topics

*Respiratory Emergencies
*Dr. Blue, Blue-cart, Code 99, or whatever you call it
*Clinical Cardiology
*Rheumatology
*Renal Disease
*Quality of Care—Appraisal Workshop
*Proctological Problems
*Pathology for the Practitioner
*Urological Problems

Afternoon Lectures

Nov. 15: *Hemodynamics and Nutrition,* Joseph A. Moylan, MD, Asst Prof of Surgery, UW Medical School; *The Internist's Concerns,* Marvin L. Birnbaum, MD, Asst Prof of Medicine and Physiology, UW MS

Dec. 14: *The Emergency Room Physician's Concerns,* Joseph A. Moylan, MD; *The Cardiologist's Concerns,* Neville Bittar, MD, Assoc Prof of Medicine, UW MS

Jan. 17: *The Anesthesiologist's Concerns* S. Craighead Alexander, MD, Prof and Chrm, Dept of Anesthesiology, UW MS; *The Obstetrician's Concerns,* David A. Horwitz, MD, Asst Prof of GYN OB, UW MS

Feb. 15: *The Psychiatrist's Concerns for the Patient and Family,* John H. Greist, MD, Prof of Psychiatry, UW MS; *The Physiatrist's Concerns,* speaker to be announced

Fee for all four programs: $30; each program less than four: $8. Checks payable to: CES Foundation.

Advance registration should be made with David C. Reynolds, Director of Scientific Services, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701. (See form at left)

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* * *

This holiday greeting will benefit Project HOPE, through the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin.

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to the State Medical Society of Wisconsin

Box of 25: $4.50 (2 lines imprinted for an additional $2.50, any quantity). Orders for imprinting must be received by December 1. Send orders to: Woman's Auxiliary to SMS, Box 1109, Madison, Wis. 53701. Be sure to include quantity desired and the name to be imprinted if desired.

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September 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1972:

Nonrestricted

Woman's Auxiliary to the State Medical Society of Wisconsin	Contribution
State Medical Society Members	Voluntary contributions of 11 MDs
O. W. Hurth, MD	Memorial: Mrs. Edgar Rappold
Margaret K. Pharo	Memorial: Fred C. Sprain
Wisconsin Physicians Service	Memorial: Fred A. Anstett
State Medical Society	Memorials: Chester C. Schneider, MD, Donald C. Wilkinson, MD, B. J. Baumle, MD, A. L. Babbitz, MD, Mr. Wm. D. Hoard, Jr.
Woman's Auxiliary to the State Medical Society of Wisconsin	Memorial: Mrs. Stephen Ambrose, Robert Dewitt, MD
Farrell F. Golden, MD	Memorial: Richard Inman, MD
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Dr. and Mrs. E. J. Nordby	Memorial: Mrs. George Vogt
J. H. Armstrong, MD	Contribution

Student Loans

State Medical Society Members	Voluntary contribution of 1 MD

Kenosha County Medical Society Student Loan Fund

Kenosha County Medical Society	Contribution

Medical Student Summer Externship Program

D. Frederick Ruf, MD, Jensen Clinic, St. Luke's Memorial Hospital—Racine	Contributions

Tormey Memorial Fund

Dr. and Mrs. T. W. Tormey, Jr.	Memorial: Mrs. David H. Johnson

W. W. Hildebrand Esq. and G. B. Hildebrand, MD Memorial Account

William B. Hildebrand, MD	Contribution
Riverside Clinic Staff	Memorial: Mr. Harvey Kiefer

Restricted

George R. Andrews, MD	Contribution

MEDICAL MEETINGS . . .

American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, September 27–29, 1973, Americana Hotel, Bal Harbour, Florida.

This conference will present *updated* information by leading authorities in epidemiology, pathogenesis, etiology, host factors, detection, diagnosis, treatment and rehabilitation in cancer of the colon and rectum.

Sessions are open to all members of the medical and related health professions. Pre-registration is requested. There is no registration fee.

Accredited by the American Medical Association Council on Medical Education.

For information write: Sidney L. Arje, MD, Second National Conference on Cancer of the Colon and Rectum, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

University of Colorado School of Medicine—Postgraduate Calendar: 1973.

Jan. 21: Colorado Academy of Family Physicians Annual Sunday Symposium

Jan. 22–27: Nineteenth Annual General Practice Review

Mar. 5–10: (Repeat of above January session)

Feb. 12–16: High Risk Infant Care (limited)

Feb. 21–24: Sixth Annual Symposium on Surgery of the Hand

Apr. 26–28: Clinical Dermatology for the Family Physician (limited)

June 11–16: Nineteenth Annual General Practice Review (Estes Park) (repeat of January and March sessions)

Dates are subject to change. Further info: Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

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trends

The Wisconsin Regional Medical Program, Inc.

NOVEMBER, 1972

Governor's Task Force Gives Nod to Wisconsin RMP For Development of Quality Maintenance Program

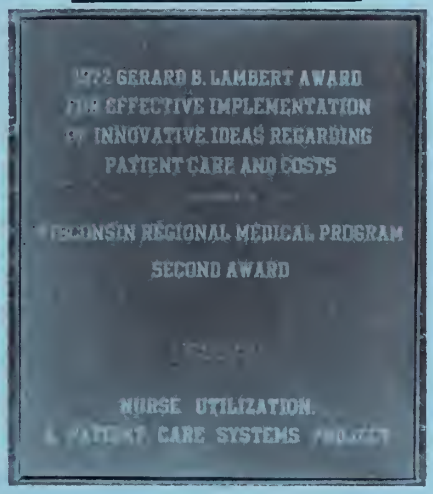
The Governor's Health Planning and Policy Task Force has approved a recommendation that the Wisconsin Regional Medical Program play a leadership role in the development of a health care quality maintenance program for Wisconsin.

"With the approval of the recommendation on October 23, the Governor's Task Force has affirmed its position that quality maintenance is a public as well as a professional responsibility," according to Dr. John S. Hirschboeck, Wisconsin RMP Coordinator. "As quality review programs are established throughout Wisconsin, the role of the Wisconsin RMP is going to become even more vital in assisting the providers of health care to meet these responsibilities."

According to the report approved by the Task Force the Wisconsin RMP is an appropriate agency for carrying out the recommendations because it "maintains a close working relationship with educational and research institutions and the providers of health care. It is recognized as an agency which can effectively bring about collaboration among the providers of health care and interrelate the interests of these providers with consumers and government."

The Task Force recommended that:

1. The Wisconsin Regional Medical Program should continue to sponsor and support the development of pilot programs in quality surveillance methodology at both the local and state level. Evaluation within such projects and the scope and effectiveness of quality maintenance methodology, including the acceptance of the health care quality maintenance system by providers and consumers, should be utilized as the recommendations within this proposal are implemented.



LAMBERT AWARD WINNER — The Wisconsin RMP was the recipient of the second place 1972 Gerard B. Lambert Award for encouraging innovative programs to improve the quality of patient care and/or reduce health care costs. The Award, administered by pollster George Gallup and the first ever presented to a regional medical program, was presented for the design and implementation of the "Nurse Utilization: A Patient Care System Project." More than 1,000 programs from throughout the country were reviewed by the Lambert Awards Committee.

2. The Wisconsin Regional Medical Program should actively collaborate with the Wisconsin Hospital Association, medical, dental and other health professional societies, and, in general, the providers of health care services to assist individual hospitals and Health Maintenance Organizations, including county medical society foundations, to establish internal quality maintenance procedures which are acceptable and which interrelate with the guidelines and standards developed by the Health Services Quality Maintenance Agency, and which are acceptable as well to Areawide Health Planning Agencies. The Wisconsin RMP would provide consultation to assist the providers to implement quality maintenance procedures.

3. The Wisconsin Regional Medical Program should promote the implementation of educational programs to assure that professional knowledge and expertise is maintained at a level to meet the quality requirements.

Executive Committee Appointed By Group

The Regional Advisory Group has appointed the following as members of the Wisconsin RMP Executive Committee:

Roger A. Baird, Secretary of the Kimberly-Clark Corporation, Neenah; Kenneth D. Clark, Staff Representative, Wisconsin AFL-CIO, Milwaukee; Mrs. Robert E. Dineen, Chairman of the Executive Committee since its formation in October, 1969, Vice President of the Mental Health Planning Committee, Comprehensive Health Planning Agency of Southeastern Wisconsin, Inc., Milwaukee; Mrs. Warren Lensmire, former Executive Director, Central Wisconsin Economic Opportunity Committee, Inc., Stevens Point; Thomas C. Meyer, M.B., B. Ch., M.R.C.P. (Edin.), Associate Dean of Postgraduate Medical Education, University of Wisconsin Medical School, Madison;

E. J. Nordby, M.D., Chairman of the Council of The State Medical Society of Wisconsin, Madison; George R. Seidenstricker, Associate Administrator, St. Alphonsus Hospital, Senior Vice President of the Executive Committee of the Comprehensive Health Planning Agency of Southeastern Wisconsin, Inc., Port Washington; Philip T. White, M.D., Associate Dean, Medical College of Wisconsin, Milwaukee; Marie J. Zimmer, R.N., Director of Nursing Service, University Hospitals, Madison.

Dr. Hirschboeck Receives WHA Award

Dr. John S. Hirschboeck, Coordinator of the Wisconsin RMP, was the recipient of the Wisconsin Hospital Association's Award of Merit presented at its annual meeting in Oshkosh, October 26.

The award, presented by WHA President Dean K. Roe, Administrator, Milwaukee Psychiatric Hospital and President of the Kurtis R. Froedtert Memorial Lutheran Hospital, Inc., was made in recognition of "long time devotion to the interests and problems of hospitals in Wisconsin, and to the humanitarian services they represent."

Prince Named EMS Director

John W. Prince has been named Project Director of the Emergency Medical Service Project.

The announcement was made jointly by Dr. John S. Hirschboeck, Wisconsin RMP Coordinator, and Warren R. Von Ehren, Executive Director, Wisconsin Hospital Association.

Although funded by the Wisconsin RMP, the project will be administered by the Wisconsin Hospital Association.

Prince, 37, was the Executive Director of the Central Minnesota Health Planning Council since 1970. Prior to that time he was employed by the Minnesota Hospital Association and also served as the Welfare Director, Jackson County, Minnesota.

John W. Prince

The Wisconsin RMP received $1.2 million to implement a two year Emergency Medical Service Program in Wisconsin which will tie together statewide communications links and establish training programs to meet on-site emergency needs. The award for the project was the largest ever received by the Wisconsin RMP for a single project.

Prince will be located at the Wisconsin Hospital Association headquarters in Madison.

Standards Available For Development of Cardiac Surgery Units

The Wisconsin RMP is making available reprints of the "Potential Need and Standards for Development of Cardiac Surgery in Wisconsin."

The article lists standards recommended by a group of Wisconsin cardiologists and cardiovascular surgeons at the request of the Wisconsin RMP. It originally appeared in the August issue of the Wisconsin State Medical Journal.

The standards were developed by Dr. Dean Emanual, Marshfield; Dr. Erik Gundersen, La Crosse; Dr. Harold Harding, Appleton; Dr. Donald Kahn, Madison; Dr. Ben Lawton, Marshfield; Dr. Francis Rosenbaum, Milwaukee; Dr. George Rowe, Madison; Dr. Daniel Thearle, Green Bay.

The guidelines were developed by the Wisconsin RMP at the request of planning agencies and hospitals from throughout Wisconsin considering the development of cardiac surgery units.

Copies of the article are available by writing: Wisconsin Regional Medical Program, 735 North 5th Street, Milwaukee, Wisconsin 53203.

Guidelines are presently being established for radiotherapy centers throughout Wisconsin. It is expected these standards will be available about April, 1973.

Report States No Need For Optometry School

A report developed by the Wisconsin RMP Optometry Committee states that, at the present time there is no need for the establishment of a college of optometry in Wisconsin and that a joint committee of ophthalmologists and optometrists be established to study long range needs.

The report, developed at the request of John C. Weaver, Ph.D., President, University of Wisconsin, also suggests that the University of Wisconsin-Extension develop a continuing education program for optometrists to give them "an opportunity to improve their ability to recognize conditions that require medical care."

At the present time there are 12 schools of optometry in the United States. In 1970, there were 427 active optometrists practicing in Wisconsin and approximately 20,000 in the United States.

Mail List Available to Professional Groups and Institutions

The Wisconsin RMP has developed a mailing list of 37 groups (37,000 individuals) from throughout Wisconsin to be used to facilitate professional health and education groups with their education or information programs.

The list, developed in cooperation with the Medical College of Wisconsin, is available on a cost-or-service basis. It will not be made available to any organization or institution for fund raising purposes or for commercial use.

The list is available in a number of ways including specialties in specific geographical areas within Wisconsin.

Organizations cooperating with the Wisconsin RMP in making their listings available include:

- Civic Organizations
- VNA's-City Health Departments
- Health Care Agencies
- State Health Office
- Wisconsin LPN Association
- Milwaukee County — Mental Health Association
- Wisconsin Hospital — Public Relations Directors
- Hospital Administrators
- Wisconsin Occupational Therapy Association
- D.D.S.
- Wisconsin Public Health Association
- Newspaper, Radio and T.V.
- Firms employing 100 or more
- CHP — West Central
- Wisconsin Pharmaceutical Association
- American Association for Inhalation Therapy — Wisconsin Chapter
- Wisconsin Physicians
- Wisconsin Nurses (RN's)
- Wisconsin Optometrists Association
- Wisconsin State Podiatry Society
- Wisconsin Society of Radiologic Technologists
- CHP-Southeastern Wisconsin — Corporate Membership
- CHP-Northwest Areawide — Board of Directors
- CHP-West Central — Board of Directors
- CHP-Northcentral — Board of Directors
- CHP-Western Wisconsin — Board of Directors
- CHP-Northeast Wisconsin — Board of Directors
- CHP-Lake Winnebago — Board of Directors
- CHP-Health Planning Council — Madison, Board of Directors
- American Cancer Society — Milwaukee Division Board of Directors
- American Physical Therapy Association — Wisconsin Chapter

The cost of the service is as follows:

Printing of labels, labeling and packaging, $13.50 per 1000. There is an initial setup charge of $10. All inquiries regarding the list should be addressed to: Director, Public Information, Wisconsin RMP, 735 N. 5th St., Milwaukee, 53203. Please enclose a sample copy of the materials to be mailed if possible.

Quality

By

JOHN S. HIRSCHBOECK, M.D.

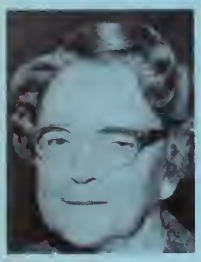
Program Coordinator

The Governor's Health Planning and Policy Task Force is recommending that the Wisconsin RMP sponsor a program to assist the providers of health care to measure and evaluate the quality of the services they perform. The Department of Health, Education, and Welfare is encouraging the Regional Medical Programs to provide this assistance and urges them to take leadership to improve quality surveillance in their regions.

Quality assurance does not always mean the same thing to different consumers. To some it means getting one's money's worth; to others it means that good professional performance is assured; and to yet others that the services they want are available when they want them. The professionals, on the other hand, judge quality in professional and scientific terms, namely, whether the services were performed at a level which meets the 'state of the science and the art" prevailing in the region.

Evaluations of quality are usually measured in money costs, because these are more tangible. Low cost and low quality are not necessarily synonymous. Cost control and quality control are, however, intimately related but should be dealt with separately if wise and prudent decisions are to be made. Cost is measured in terms of effective resource utilization. Quality is concerned more with the effectiveness of the services performed. Measuring, comparing, and evaluating the cost of health service is less difficult than measuring, comparing, and evaluating the quality of health care, because the methods are already known to commerce and industry. A sophisticated evaluation of quality will require the development and introduction of new methodology, and it is here where the Wisconsin RMP will be playing an important role. We hope that we will be able to collaborate with the groups which are forming to carry out the requirements in new Federal legislation calling for the establishment of Professional Standards Review Organizations (PSRO). We have made a good start in Wisconsin with the formation of Wisconsin Health Care Review, Inc.

New Members, Officers Appointed To Wis. RMP Regional Advisory Group



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WRMP Program Coordinator
John S. Hirschboeck, M.D.

WRMP Director, Public Information and Communications
Peter A. Kirsch

Just a Reminder!

Wisconsin RMP has moved to the following locations:

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735 N. 5th Street
Milwaukee, Wis. 53203
Tele: (414) 272-3636

MADISON — Planning
5721 Odana Road
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the wisconsin medical journal

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Publication of the *Wisconsin Medical Journal* is under the direction of the Council of the State Medical Society of Wisconsin, with coordination through the Commission on Scientific Medicine. The Medical Editor and Editorial Board are responsible for the Scientific Content. The Editorial Director is responsible for Editorials. The Managing Editor is responsible for the production, business operation, and all other contents of the *Journal,* as well as final responsibility of the entire publication. Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed in the pages of the *Journal.* In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

PRESIDENT'S PAGE

Year's End—1972

THE CALENDAR IS REMINDING US all that 1972 is about to slip into history and with it memories of a fateful period in medicine and the nation. The presidential campaign and Richard M. Nixon's smashing victory undoubtedly dominated this year. It could be richly enhanced if by year's end the horrendous Victnam War is ended. Politics has played a heavy hand in the story of 1972.

On October 30, President Nixon signed into law Public Law 92–603 providing amendments to the Social Security Act which spell out major changes in the Medicare and Medicaid laws enacted in 1965. It is difficult at this time to estimate the full impact of this multi-billion dollar governmental medical care program. The new law provides Medicare benefits for the catastrophic costs attending chronic renal disease needing dialysis and for those under 65 who receive Social Security disability benefits. This fine gesture by Congress ignores untold numbers of our patients who are victims of chronic heart disease, stroke, cancer, and crippling neurological disease to mention a few. None of us ever wish to see a family bankrupted because someone falls heir to any crippling disease. The new law embodies many other changes in governmental medical care programs which have been widely reported in the news media.

The PSRO—Professional Standards Review Organization—better known as the Bennett Amendment, set the stage for a special medical services conference at the American Medical Association Convention in Cincinnati on November 25. The State Medical Society of Wisconsin with its well organized Wisconsin Health Care Review, Incorporated, provided an important part of this national conference. Wisconsin is one of few states in the nation with a well developed working plan for peer review. The AMA House of Delegates later adopted a plan of complete physician cooperation in developing PSRO mechanisms as part of the new law. The medical profession has a vital stake in making this review process work for its own good name and in the public interest.

In sharp contrast to the program of improved medical care under the new law, the United States Senate saw fit to ignore the pleas of the Department of Health, Education, and Welfare; the American Medical Association, and a powerful appeal by Senator Edward M. Kennedy against including chiropractic under the new law. This wierd cult, simply through intensive, unrelenting, lobbying efforts succeeded in getting themselves included in the Medicare program. Payments, however, will be for "subluxation" only when proven by x-ray. Medicare will not pay for x-ray.

Within our own state, the Chiropractic Study Committee to the Governor's Health Planning and Policy Task Force filed a devastating report on October 23 on the whole subject of this cult's operation. Members of this Committee are: Gilda B. Shellow, chairman, a Milwaukee attorney; William L. Blockstein, PhD, professor of pharmacy at the University of Wisconsin; and Robert B. Durkin of Milwaukee, vice-president of the Milwaukee County Labor Council, AFL–CIO and a member of the Board of Directors of the Wisconsin State Labor Council, AFL–CIO. They are to be congratulated and publicly thanked for this unique and thorough report.

Another year lies before us filled with known and many unknown confrontations affecting the practice of medicine. Whatever it might be—we must never for a moment falter in the pursuit of truth.

Robert F. Purtell MD

ROBERT F. PURTELL, MD

Editorials

EDITORIAL DIRECTOR

Raymond Headlee MD Elm Grove

WISCONSIN
MEDICAL JOURNAL

Transition—fourth of a series

In the first three parts of this series the ground work was laid for at least a start toward understanding what is happening to us, not only in medicine but also in our lives. The curious meld of widened horizons with vastly increased choices is a base from which a richer life could come. Or, as will be discussed here, this base of expanded choices may actually lead to expanded conflict.

Now, conflict over goals is simply a part of human history. We know our own choice of medicine as a profession; while it suited us and in some cases our families, it could sometimes be a source of conflict. This could occur if significant persons in our lives wanted something different for us. Then, through our choice of mode of practice and area of practice, we are faced with strictly personal, up to now, choices. Whether a man does private practice alone, or in a group or for a salary in government or institutions, was considered merely a facet of his personality. What moves he made to specialize or not to specialize were likewise a matter of choice, or at least chance. And further, what we chose to *do* in this practice was pretty nearly our own business; e.g., to study regularly, to learn by doing, to attend courses, to compare cases with our peers.

Today the center of gravity has shifted from the personal and economic issues squarely to the political arena. This is no plot by persons designated "political" to deprive us of our civil liberties, although some may feel it is. The pejorative use of the term "political" really avails us little, for while there are certainly some, or even many, in the public service who would move us toward control, they would be as ineffective as was Harry Bridges in 1930, were it not for the ground swell of *public* interest in the issue of control. This may be a more true meaning of the "shift to political," mentioned above.

In our profession we see social conflict mostly as economic, for instance that a person we treat is placed in double jeopardy by illness. We believe sometimes that this can be solved by insurance policies. We may even put some of our hard earned cash away for just such eventualities for protection of ourselves and our family. But this is only one of the issues which the *public-politic* is becoming urgent about. They are demanding, and even searching desperately for new ways to handle these—and many

other social conflicts. For my purpose here, the action has shifted from static to political in many other areas—public housing, income protection, racial equality, legal services, and the like. Our concern will be primarily for the closure that is being forced in medicine, but it would be folly to believe that only medicine is involved at this point in history.

But a far more profound challenge is *evolving* in regard to medicine. Just as political and legal institutions are being questioned, so are our notions of medicine as an established institution. It is not physicians as individuals who are called into question, although this sometimes occurs. It is not only the need to pay physicians' fees that is being questioned. I'm afraid we are now faced with the entire question of how to practice medicine—in all its aspects. The questions can be mild, such as the best way to bring new discoveries to the attention of wider segments of the public. Or, the questions can be fierce, such as how can we be sure medicine is after all the best answer, or that medical systems of diagnosing and treating (not merely how to pay for it) are truly the best. Ralph Nader is but one man, and while I'm not able to know how much he is cause and how much he exists to serve the emerging POLITICAL DEMAND for answers to these medical questions, his inquiries are certainly typical of the issues being raised. Psychiatry has long been challenged by social work, clinical psychology, and now by encounter groups run by sensitive artists. Medicine felt the sting of legislator and governor in the recent laws allowing the public free choice of healing methods, with no reference made to our sacred tenets of science and service. This is just the start.

A little noted but soon to be felt aspect of these demands to determine method and quality is that of abrogation of our traditional privacy. As more and more decisions are made publicly available through consumer review groups, through "exposure media," and through more challenging detailed reporting for insurance, medicine, hospital and even patient needs, the old notion of privacy seems lost. The slogan of the masses in Aldous Huxley's *Brave New World* was "everybody belongs to everybody else." So if our notions of peer review include printing the name, age, diagnosis, nature and frequency of treatment of all patients seen by any one doctor in a group; e.g., hospital staff, and sending this printout to every other doctor in the group, then what is the cost of this in privacy, and how does this match the gain in effective peer review? I have no opinion, now, on this system, already in effect in Wisconsin. It does illustrate how we are forced to new political ways of practicing medicine. And this is only one of many issues which will face us increasingly. Whether this is some new direction in social evolution or someone's plot, or a mere function of the increasing mass of people, I cannot say. Certainly the side-effects of even these seemingly innocent peer review mechanisms are not yet felt. Recently another editor and I debated the privacy issue in regard to venereal disease.* The issue was whether forced exposure would help eradicate VD. Without being in favor of hiding everything, I did raise the point that fear of exposure, even to a friendly doctor, should be taken into account in the balance of things. Now if all information were circulated about a hospital, or a community (including the eyes of the typist and all of the office staff of the doctors), then the anxiety surrounding VD might disappear, as some say, or it might drive the person further underground. The same for mass reporting of diabetes, mild heart attacks, kidney dysfunction, and other things until now considered personal. Privacy will go, but how and when and in what form is one part of the present political crisis in medicine.

—RH

* *Milwaukee Medical Times,* May 1972. □

Wisconsin Students: Short of Cash?

The State Medical Society's Charitable, Educational and Scientific Foundation (CESF) has money available for long term, low interest loans which are interest-free until after medical school is completed. The loans are designed to "fill the gap" for students whose own resources aren't quite enough.

CESF funds are limited, so the loans can only be given to Wisconsin residents enrolled in Wisconsin medical schools—The University of Wisconsin Medical School in Madison and The Medical College of Wisconsin in Milwaukee. Deans of the medical schools must approve the applications before loans can be granted.

CESF loans are generally under $1,000 a year for a total of three years. Application forms and complete information are available at the CESF office, 330 East Lakeside Street, Madison.

Funds for these loans have been given to the Foundation to administer according to the wishes of the donors. Several of the loan programs have been set up by county medical societies for students from within that county. Physicians individually have established loan programs and others have contributed significantly to the general student loan program. Industry, too, has contributed substantially.

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

Acupuncture Editorial Stirs Comment

Your remarks in the *WMJ* October 1972 issue on acupuncture seem more emotional than scientific. Ideas which shake the foundations of currently accepted theory should probably not give rise to negative or unpleasant feelings in a true scientist, but rather to a guarded curiosity or perhaps an intriguing interest.

Kirlian photography supports the theory that living things have both a material body and an energy body. This energy body maintains its integrity even when the material body is altered. For example, if less than a third of a living leaf is cut off the Kirlian photo still appears whole; if a finger is cut off the Kirlian photo still shows the whole hand. This energy flows out of the material body through definite channels and the color and intensity vary with the health and feelings of the individual. There is a possibility that acupuncture points may be related to these channels of energy outflow and that stimulation of these areas may affect the energy pattern within the body. When this energy pattern is controlled by special training the physiological processes, including respiration and circulation, can be temporarily suppressed to the point where they are no longer detectable. A person in such a state can be buried in the ground for more than a week and recover without apparent harm.

All of these phenomena are difficult to study and, as you suggest, no scientific conclusions can yet be reached. Therefore, it seems prudent to avoid making the kind of value judgments implied by the use of words such as "wierdos" and "kooks." Just because some enthusiasts go overboard and make premature dramatic statements in the mass media is no reason to do the same in opposing them.

Empiricism is still a part of modern medicine, which is practiced as both science and art. The art part, which is related to the physician's understanding of the whole patient and the confidence the patient has in his personal physician, would be hard to justify in the face of a purely scientific objection such as the one you have raised against acupuncture. There is certainly no danger that the reliable and practical scientific method is about to be discarded, but neither is it likely that the scientific method will soon entirely replace intuition and human concern in any sensible approach to the solution of man's health problems.

RICHARD BIEK, MD
Madison, Wisconsin

The editorial by Dr. David Goldstein on Acupuncture printed in the October, 1972 issue of the *Journal* would indicate that he has completely made up his mind on this subject. It is a cult, he states, comparable to chiropractic, wearing copper bracelets, etc., with a cure rate comparable to a visit to Lourdes, the application of leeches, or drinking bowls of chicken soup.

Most innovative procedures frequently stimulate widespread reaction, particularly if it is outside the realm of normal experience. Jenner's experimentation with cowpox fortunately was not designated as a fad, though antagonism to it was widespread for very many years.

My knowledge of acupuncture is limited to what I have read, but I do not intend to prejudge the issue. There is nothing less scientific than making up your mind on a subject about which you know next to nothing. I will keep an open mind and await the investigative work that is now being done.

THEODORE ROWAN, MD
Pathologist
Beaver Dam, Wisconsin

Physician's Widow Grateful

I am returning the notice of my husband's death, corrected to change the date of his death to September fifth. Thank you for giving me the opportunity to read it prior to its publication.

I appreciate, also, your letter and the reprint, both of which contain helpful suggestions. Fortunately I have a brother who is a lawyer; he has been invaluable in helping and advising in matters of immediate concern, but I was completely unaware, for example, of how to handle records. For reasons of health my husband had not been actively involved in the practice of medicine for two years, and I believe he must have disposed of a fair amount of his office equipment and instruments, though I will surely check on those and other items, such as narcotics, very carefully.

It is, believe me, a comfortable feeling to know that I can turn to your organization for help and can expect, through my honorary membership in the Academy of Medical History, to maintain contact with your organization.

MRS. DOROTHY B. GILBERTSEN
Janesville, Wisconsin □

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Highlights of Scientific Program

THEME: EVALUATION AND THERAPY OF COMMON ENDOCRINE DISORDERS

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A.M. Plenary Session, Sections on Family Physicians, Internal Medicine, Pediatrics

Noon Socio-economic Luncheon. Speaker to be announced.

P.M. Plenary Session, Wisconsin Allergy Society, Sections on Dermatology and Public Health

Tuesday, March 27

A.M. Resident–Intern Papers Program
Plenary Session, Sections on Pathology and Radiology

Noon Roundtable Luncheons

P.M. Anesthesia, Obstetrics and Gynecology, Ophthalmology, Otolaryngology, Orthopedics, Pathology, Radiology, Surgery

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL HISTORY FEATURE

Dr. Guenter B. Risse recently was appointed Associate Professor and Chairman of the Department of the History of Medicine at the University of Wisconsin Medical Center in Madison.

Dr. Risse is a native of Argentina where he received his MD degree in 1958 at the University of Buenos Aires School of Medicine. After coming to the U.S., he first completed a rotating internship and then a three year residency in internal medicine at Buffalo, New York and Detroit, Michigan.

Thereafter, Dr. Risse returned to the classroom as a student of the Department of History at the University of Chicago, receiving his PhD degree in early 1971. He has been an Assistant Professor in the Department of the History of Medicine at the University of Minnesota during the past two years.

Since arriving in Madison, Dr. Risse has reorganized the William Snow Miller Medical History Seminar which has had a long and illustrious tradition at the University of Wisconsin Medical School. He is interested in the historical projects of the State Medical Society of Wisconsin and presently serves on the Selection Committee of the History of Medicine Scholarship Awards presented by the Society's Charitable, Educational and Scientific Foundation.

Shamanism: The Dawn of a Healing Profession

GUENTER B. RISSE, MD
Madison, Wisconsin

TO STRESS THE FACT that medicine, to a large extent, is a social phenomenon may appear to be redundant. However, the process of *human healing* is intimately connected with a patient's individual values and closely related to his society's spiritual and cultural tenets.

The present growth of medical science, impressive and spectacular, has unwittingly displaced the sociological aspects of healing which clearly transcend the purely biochemical dimensions. A laudable concentration upon electrolytes and enzymes has somewhat displaced the emotional components of illness. Moreover, the interplay of the sick individual with his family and society at large has also faded into the background.

While physicians continue to increase their knowledge in the biological sciences and expand a technology geared to relieve physical suffering, they should not forget nor minimize the social component. In fact, physicians should increase their awareness of the important role which emotions actually play in health and disease. Perhaps one of the responsibilities of the future family practitioner will be to consciously assume the part of a medical sociologist, a role which his horse and buggy ancestor played rather extensively in the absence of effective scientific healing measures.

This paper is a condensed version of the first lecture given before the reorganized William Snow Miller Medical History Seminar, Nov. 17, 1971, in Madison.

Doctor Risse is Associate Professor and Chairman of the Department of History of Medicine, University of Wisconsin Medical School, Madison.

Reprint requests to: Guenter B. Risse, MD, Department of History of Medicine, UW Medical School, 1305 Linden Drive, Madison, Wis. 53706.

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In this framework of social medicine, I should like to stress the fundamental characteristics of the medical profession's oldest ancestor, the SHAMAN. The term shaman is taken from the Tungus language spoken in Central and Eastern Siberia as well as Manchuria. In that language, the term shaman means "restless and excited" and was given initially to a priestly and healing authority.[1] Now, by extension, the word is applied to other persons with similar religious and medical functions who exist in other primitive societies throughout the world.

The shaman carries out multiple activities, and the term *shamanism* designates a series of magico–religious procedures including healing. These activities have recently attracted a great deal of attention, especially from historians of religion, ethnologists and cultural anthropologists.[2]

Most of the knowledge concerning shamanism has been gathered from contemporary or near contemporary primitive societies.[3, 4] However, one can project its basic pattern into our prehistoric past on the basis of a number of archeological as well as linguistic sources. The roots of shamanism go back at least to the Alpine paleolithic period, about 30–50,000 years ago.[5] Hence, shamanism probably represents the earliest and most prestigious mode of healing.

One can assume that the earliest stage of human culture was a hunting society composed of small groups or tribes, probably with no more than 100–300 people each. These prehistoric groups, like the contemporary savages, were impressed and outright fearful of the potentially hostile forces encountered in their environment. Against this background of a world filled with mysterious causes and effects, the primitive tribes had a desire to assert themselves in the midst of what they considered to be an inferior and weak position.[6]

As in the past, two important situations must be dealt with: *death* and *dreams*. The meaning of death remains unclear, but the fact that bones, hair and horns in animals seem to survive death engenders conceptions of after-life or resuscitation. Dreams, on the other hand, establish the fact that part of man seems to be able to separate from the body and travel thus unseen to distant places, performing a variety of deeds in the process. Therefore, dreams establish the belief in a detachable life-essence or soul, expressed by the term *animism*.[7] This soul can leave the body during periods of natural or induced sleep, as well as during coma or after death. Dreams also seem to confirm the impression of an existence after life. Known dead family members and friends interact with the dreamer and perform numerous activities.

The result of these dreamed actions is a belief that man, animals, and all of surrounding nature can be divided into a physical component obvious to the senses. By contrast, another invisible realm, spiritual in character, is postulated, perhaps residing in parts of the body not susceptible to immediate corruption.

Once the idea of an invisible, spiritual plane has been accepted, this dimension acquires greater importance than the physical one. The spiritual component accounts for intentions, emotions, and the will for actions. Therefore, it becomes the object of primitive man's desire to gain mastery over his environment. He wants to influence the spiritual dimension of all the cosmic forces and the living creatures which he hunts, independent of his technological efforts.

Because of the existence of such a spiritual realm, somebody within the tribe or hunting group has to make contact with the invisible nature. Such a man is the *shaman,* a combination of priest, magician, and medicine man. The shaman occupies a central position in his society, and is considered the bearer of a special gift whereby he can communicate with the other invisible world.[8]

Hence, the shaman specializes in psychic phenomena. These are usually states of trance or autohypnosis during which his soul is believed to leave his body, traveling to the underworld or ascending to the sky. The shaman controls the spirits which he encounters during his sojourn. In fact, he is considered to be the only human being who can communicate with invisible forces without becoming their instrument or victim. For this purpose he carries out rather lengthy rites at times to protect himself from such a fate. The shaman, in this regard, is a specialist of the invisible soul who merely confirms and emphasizes the group's own religious ideas and mythical notions of the universe. This explains the reasons why shamanism is functionally related to religion.

However, shamanism is also involved in very important socio–economic questions. The shaman is often called upon to help the tribe succeed with their hunting activities which spells the difference between well-being and starvation. Through certain rites involving mass-hypnosis, the shaman can bolster the morale and restore the confidence of his people. The shaman is also called upon for help in times of collective anxiety and uncertainty when the fertility of the society's female members seems disturbed as a result of an abnormal emotional state. Here again, the shaman's techniques are aimed at dispelling the prevailing fear and inspiring new hope.

The shaman's healing functions involve the diagnosis of disease by the establishment of an offending cause. This activity is then followed by efforts to remove the invading spirit or restore the soul to those who seem to have lost it during periods of unconsciousness.

The person or persons selected for the performance of shamanistic tasks seem to have certain obvious peculiarities, stemming either from organic disease, personality disorders or overt mental illness. A member of the group displaying some eccentric behavior in his young years, or someone exhibiting hysterical fits, convulsive seizures or cataleptic states, has the potential for becoming a shaman. In most cases, the young person's initial symptoms are interpreted by the society as a so-called "call," or election to shamanhood. The aberrant behavior is considered a gift of the gods, whether it be spontaneous or hereditary. In any case, the group interprets the episodes as an outward manifestation of the future shaman's battle with the surrounding invisible world of spirits or demons.[9]

Once such a call has been clearly recognized, the budding shaman is subjected to an apprenticeship which may last six to ten years. Under the guidance of an established shaman, the student is expected to learn the techniques and symbolisms necessary to carry out his later duties.

The shaman is called upon to deal with all those diseases which we would term internal and mental, usually considered to be supranatural in character. The first question facing him is: *what is the cause of the illness?* Assuming that the responsible agent is supranatural, the shaman can simply conclude that the patient's soul has left him and gone astray somewhere in the underworld. Or, he can postulate that an evil spirit has intruded and taken possession of the sick person. Other diagnostic choices include breaking a tabu, followed by divine punishment, or the establishment of an illness through magical manipulations of a sorcerer.[10]

Faced with this potential variety of diagnoses—not all of them, however, coexist in any given social group—the shaman determines the cause of disease in an individual patient. His most common procedure is divination. He guesses the cause by going into a trance, interpreting his own visions or dreams, or in more advanced societies, makes use of astrology. Because of his ecstatic technique of autohypnosis, his soul is believed to abandon his body and travel through the invisible roads of the extraterrestrial regions in search of the right answer.

The second question which confronts the shaman is: *what form will the sickness take and how can it be removed?* In the case of soul loss, the shaman is supposed to search for it, hopefully find it and capture it in order to return such a lost spirit to its rightful body. The disease object intrusion, on the other hand, is handled through the extraction of a hypothetical noxious substance or object from the body. The spirit intrusion is handled through exorcisms, verbal ejection or mechanical extraction, while the breach of tabu involves the need for the patient to confess and clearly acknowledge the hypothetical offense for which he was punished with disease.

To carry out these various and complicated tasks, the shaman usually employs some friendly spirits in animal form. He imitates the actions and voices of certain powerful animals and is supposed to take possession of their spirits, thus inheriting some of their outstanding qualities. Through gesture and with the help of masks, the shaman occasionally turns himself into an animal.

Recently, some authors have viewed shamanism as a psychopathological phenomenon—in short a mental disease. Some have called it an "Arctic hysteria" which occurs presumably under the conditions of extreme cold, desert solitude, and perhaps vitamin deficiencies. However, the phenomenon of shamanism can be found in virtually all of the world's primitive societies. Its Arctic occurrence is in some measure connected with the existence of native populations in that region which have little or no contact with modern civilization.[11]

The question whether the shaman is a normal human being or an individual afflicted with certain illnesses, which by themselves create the natural qualifications for his profession, is a pertinent one but actually difficult to answer. A recent paper on the subject has correlated the shamanic inspiration with the behavior of acute schizophrenic persons. In this view, there are valid arguments stressing the shaman's initial feelings of impotence and failure, his subsequent isolation and estrangement. It is said that in the end, the ensuing self-initiated sensory deprivation contributes to the fragmentation of the shaman's concept of himself, completely shattering his personality. Changes in his sexual role and the appearance of transvestism are adduced as additional proofs of this derangement.[12]

The thesis is that these schizophrenic experiences are not only tolerated but actually rewarded in primitive societies, allowing for a mental and emotional reorganization of the mentally ill shaman. It would appear that the primitive society offers a collective solution to the problem associated with their severely and mentally ill members, alleviating their sufferings by providing them with a useful role in which their disturbed behavior is considered appropriate.[13]

However, no firm data is available as yet for properly evaluating the personality development of the shaman. Almost all primitive cultures experience a variety of cross-cultural contacts and interactions, which make them dynamic and changing units rather than monolithic islands of frozen beliefs and customs.[14]

With such a dynamic perspective in mind, it is difficult to envision how an unstable shaman, afflicted with severe mental disease can actually function. The contrary is true, however, and many shamans have stable and well-integrated personalities showing no sign of mental disintegration whatsoever. In fact, some contemporary shamans possess a keen perception of reality, a great native intelligence and in many instances tremendous artistic talents. Many of them achieve a keen insight into the problems of their group and know its members extremely well. These qualities point to the rather exceptional character of some shamans within the societies which they serve spiritually.

Because of these contradictory findings, other authors have speculated that these shamans actually suffer from a mental illness at the time of their selection for this role. Later during the process of learning how to shamanize, these apprentice-shamans actually heal their own mental disturbance. In this view, the self-induced hypnotic trances displace the disturbed level of consciousness and impose order and form upon the chaotic images which cause the early irrational behavior.

The shaman is distinguished from the ordinary witch doctors, herb doctors or bone setters by his uncanny ability to achieve ecstatic situations or states of psychic trance. Such an ecstacy or situation of autohypnosis is accompanied by a certain loss of consciousness during which the shaman performs his so-called "miracle" of divination, clairvoyance, telepathy and diagnostic dreams. The whole trance technique is, of course, based on the theoretical assumption that the human soul can be separated from the body. Although usually the shaman alone falls into a trance, the hypnotic state can, on occasion, be extended to a series of key participants or a whole tribe.[15]

A series of psychological experiments carried out at McGill University on sensory deprivation perhaps could shed some light on the phenomenon of shamanism.[16] During those studies it was found that the human brain is greatly dependent on a conscious registration of its surroundings through the use of the senses. If the cerebral functions are to continue their regular activity, they must be stimulated by changes which are perceived by the sensory organs. Thus, when the external stimuli become monotonous and scarce, the subject glides into a kind of dream-like state between sleep and wakefulness.

Monotonous sounds, like those produced by a rhythmically beating drum or chanting a certain song, as well as the restriction and execution of the same movements over and over, are a prerequisite. Such monotonous stimulations offer the brain only a small variety of sensory impressions. Under those circumstances, the inner frame of reference breaks down, since the sense deprivation makes it difficult or nearly impossible to continue structurizing the outside world. The breakdown is reflected in the ability of those persons to have visual and auditory experiences drawn from their inner self, phenomena which we like to call "hallucinations."[17]

If the shaman begins to have such hallucinatory experiences by following the prescribed techniques of his teacher to whom he is apprenticed, he will be very impressed. He will doubtlessly be convinced of his ability to contact the invisible world of the supranatural. Hence, no hypothesis of mental disease will have to be postulated for the shaman's visions achieved during a trance resulting from self-induced sensory deprivation.

There are two critical issues which seem to emerge from the activities of a shaman: what are his true problem-solving abilities while under hypnosis, and secondly, what is the efficacy of his psychological healing practices. Our modern world makes continuous use of verbal language and writing, structuring reality into logical units located in a framework of causality and spatio-temporal relationships. In such a way, a gradual but continuous accumulation, refinement, and correction of individual viewpoints is possible over a period of time.

By contrast, shamanism is a practice prevalent in cultural units which lack writing and more sophisticated social organization. The shaman in his trance employs mental resources which a modern person, to some extent, no longer has access to or is not interested in using in the face of a coherent, logical and rational method of conscious thought. Thus, the shaman employs an unconscious form of problem-solving which we call intuition. Such an intuition or artistic creativity is built on a series of visual, auditory, and other sensory memories as well as the abstractions and symbolisms which they represent. Instead of thinking logically and consciously about difficult problems, the shaman turns to his inner experiences through autohypnosis. He reviews his subconscious flow of pictures without the use of the critical powers activated by consciousness as well as the grid of causality, time, and space.

Therefore, the shaman activates a less precise method of problem-solving, a more primitive think-

ing process. Such an approach allows him to establish unconventional combinations, achieve unusual and inexplicable solutions which follow no logical pattern, and display surprising creativity. If the shaman possesses a capacity for contact with his subconscious store of experiences, he is able to achieve untraceable flashes of genius while in a state of trance. His utterances and the solutions he offers during the state of trance, or immediately thereafter, usually confirm and even reinforce the religious beliefs and cosmological concepts of the society.

The shamanistic healing functions constitute an area where parallels between primitive societies and our modern industrial civilizations can be more aptly drawn. In both the primitive as well as the modern society, the state of illness, mental or physical, is apt to create a series of emotional problems for the patient, his family and certain social agencies. The person who falls sick expresses anxiety and fear over his or her condition. His physical sufferings are coupled with a forced withdrawal from his usual activities and roles which he plays within society. This fact disturbs his self-assurance and damages the image he has of himself.[18]

The shaman's effectiveness in healing is primarily centered around his ability to arouse hope and furnish supranatural encouragement to those who are ill. In that respect, the shaman's personal attributes, his reputation, and prominent position within the society as well as his impressive rituals, deeply impress the patient who expects to be healed. These expectations can be compared with those elicited by a prominent and well-sought medical specialist in our modern setting.[19]

This uplift of the morale and restoration of hope in the patient is closely connected with the set of assumptions on illness and healing that he shares with the rest of his social group. Such a particular world-view cannot be shaken by failures while every apparent success validates and actually reinforces the preconceived assumptions. If the patient does not experience any improvement there are many ways of explaining away the failure without ever questioning the effectiveness of the shaman himself or his methods.[20]

The consultation with a shaman increases the patient's self-esteem by the fact that he and his problem are brought to the attention of such an important person. Likewise, those concerned or frightened relatives also benefit through shamanistic intervention. Anxieties and fears which greatly color their approach to the sick person can be largely abated. Sometimes the whole group participates in certain healing rites. They are highly therapeutical to the entire society and flattering to the sick individual, suddenly worthy of all that attention and those healing efforts.

During the trance proper and shortly thereafter, the shaman is able to offer a diagnosis and a plan of action to the person who has fallen ill and to his immediate entourage. This focuses all the doubts and fears on certain procedures, eliminating the feelings of helplessness which had contributed to the distress of the disease. The favorable responses observed in many instances of shamanism can be called, in our modern view and language, *placebo effects;* that is, they occurred through suggestion. Such a psychological component is also present in every modern drug recommendation regardless of its pharmacological action. It adds a rather imponderable factor in medical practice, even in today's most sophisticated therapeutic plans.

Therefore, shamanism works with an elaborate network of spiritual relationships created by the society in which it is practiced. All elaborate rituals, divination procedures, and therapeutic actions derive from such a magico-religious world-view. They appeal to the emotional and irrational components of the psyche, providing satisfaction for our metaphysical needs and products of the imagination. At the same time, the network allows a sense of freedom through the use of magical manipulations in order to transcend an apparent determinism imposed by the supranatural components of the cosmos.

Such a built-in escape hatch is in evidence today when many people are again attracted to the occult in order to transcend the seemingly scientific determinism. The paradox is that shamanism, like other occult sciences, is a very rigid system. The lack of flexibility is due to the traditions and values which are essential to preserve a viable structure of the society in question. Thus, extreme conservatism and insensitivity to experience are imperative qualities of such a system of religious healing.

This has a special significance when modern civilization and medicine begin to influence these primitive societies. Such a situation is now prevalent in large sections of Africa and Latin America, and is taking place in the Indian reservations of our own country. Modern medicine remains alien to them, since the primitives cannot include the scientific principles into their magico-religious network. The successful action of the modern drugs, however, cannot be overlooked even by the most skeptical observers. Thus, the natives use these remedies when they are available simply as adjuncts to relieve the symptoms of disease without having to discard their basic magico-religious beliefs.

From the modern vantage point, one can readily understand how the shaman can cure psychosomatic illnesses, provide useful supportive psycho-

therapy to the mentally ill and valuable reassurance to those afflicted with organic ailments. His wide range of success points out the importance of the social aspects of healing which have now been displaced in the face of our dramatic scientific accomplishments.

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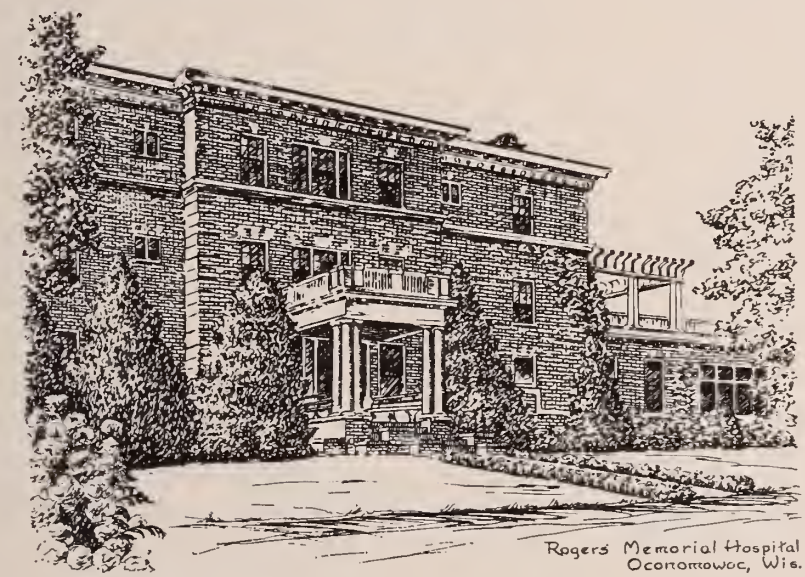

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SECTION OPHTHALMOLOGY

DECEMBER 1972 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN SOCIETY OF O AND O MEETING

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology met at Wausau, Oct. 21–22, 1972. Thomas A. Aaberg, MD and Robert A. Hyndiuk, MD from The Medical College of Wisconsin were the speakers. The Eye Clinic of Wausau, S.C. was the host for the clinical part of the meeting where patients were presented and discussed. An outstanding evening of singing entertainment was provided by Doctor Hyndiuk accompanied by several other members of the Society. The meeting was attended by 40 physicians and their wives.

New officers elected were John A. Ottum, MD, Green Bay, president; Charles F. MacCarthy, MD, Wausau, vice-president; and James C. Allen, MD, Madison, secretary–treasurer.

Eight ophthalmologists were accepted into the Society: MDs Frederick S. Brightbill and Paul Segal, Madison; Walter E. Gager, Waukesha; John M. Hattenbauer and Steven Herman, Wausau; John Shillinglaw, Appleton; Barbara Geldner, Neenah; and Robert A. Hyndiuk, of Milwaukee.

NEW OPHTHALMOLOGIST IN APPLETON

John A. Shillinglaw, MD has recently opened a solo practice in ophthalmology in Appleton. Doctor Shillinglaw grew up in Iowa and received a BA degree from Cornell College, Mount Vernon, Iowa. He received his MD degree from Washington University in St. Louis in 1968. He did an internship at University Hospitals, Madison, in 1968–1969. His ophthalmology residency was at Washington University, St. Louis, from 1969–1972. He is married and has one son.

POLISH PROFESSOR AT UW

Professor Paul Segal is working with M. D. Davis, MD at the University of Wisconsin in clinical diabetic research. Doctor Segal was chairman of the Department of Ophthalmology in Lodz, Poland, before coming to the United States. He left Poland because of political reasons.

LIONS CLUB GIFT TO UW

The Wisconsin Lions Foundation has given the University of Wisconsin a $14,000 Zeiss camera that can take fundus and slit lamp photographs of the eye. The gift was made possible through the contribution of 16,000 Lions Club members in the state of Wisconsin.

UW RESIDENT GAINS RECOGNITION

Dr. Helen Jane Blackman has been selected to the 1972 edition of Outstanding Young Women of America. Doctor Blackman received her MD degree from Indiana University. She is currently senior ophthalmology resident at the University of Wisconsin Hospitals, Madison.

COMMITTEES MEET

The Executive Committee of the Section on Ophthalmology and the Division on Vision of the State Medical Society met in Madison November 16. The meeting was conducted by Dr. W. Carson Parks, Milwaukee, chairman of the Section on Ophthalmology, and Dr. George Nadeau, Green Bay, chairman of the Division on Vision.

Other physicians attending were: Drs. Elmer E. Johnson, Madison; Dwain E. Mings, Monroe; John B. Hitz, Milwaukee; Glen E. McCormick, Elm Grove; M. D. Davis, Madison; Herbert Giller, Milwaukee; James C. Allen, Madison; Horace K. Tenney, III and Gertrude E. Howe, Madison pediatricians; and H. B. Maroney, assistant secretary of the State Medical Society, Madison.

It was reported that the Wisconsin Regional Medical Program's optometric study committee has recommended that a new school of optometry not be started at the University of Wisconsin–La Crosse. A story on the committee's recommendation appeared in the *Journal's* November issue in the WRMP TRENDS section.

Much time was spent discussing ways to help the Motor Vehicle Division set up standards for driver's license examinations.

The Section on Ophthalmology has been requested to meet with representatives of the Wisconsin Optometric Association. Although recommending that no new optometric school be started in La Crosse, the WRMP optometric study committee did recommend more cooperation between ophthalmologists and optometrists. Doctor Parks will appoint a committee to meet with them.

Section members should note that the State Medical Society plans to introduce legislation calling for the use of safety glasses in certain academic classes and the creation of a Dispensing Opticians Examining Council within the State Medical Examining Board.

The problem of dyslexia also was discussed with the pediatricians. □

WISCONSIN MEDICAL JOURNAL
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Medical
GREEN SHEET
NEWS OF SOCIO-ECONOMIC MEDICINE

PSRO: Will It "Standardize" Medicine?

PSRO. Out of the alphabet soup of federal programs comes this spoonful of letters crucial to medicine.

PSRO stands for Professional Standards Review Organization. "Peer review" is what most physicians call the job it is supposed to do.

PSRO is an important piece of the 1972 Social Security package passed by Congress in October and signed into law by the President last month. It is the federal government's vehicle for continual scrutiny of the services covered by Medicare and Medicaid.

"Standards" Is Key

The word *standards* in the title is really what PSRO is all about. Standardizing medical care is one way the federal government is going to try to meet what it sees as its obligation to hold down costs and assure quality. What worries physicians across the country is the possibility that these standards might force them into an undesirable uniformity of practice.

At its November 11 meeting, the State Medical Society's Council proposed a statewide conference on PSRO to be sponsored jointly with the state dental and hospital groups. Tentative plans call for it to be held in January.

At stake in PSRO for these three groups is the fledgling corporation they launched just a year ago, Wisconsin Health Care Review, Inc. (WHCRI). WHCRI is now being cited as a prototype PSRO.

In fact, WHCRI was one of three foundations from across the country which was asked to send a speaker to a special PSRO conference at the American Medical Association's (AMA) Clinical Convention in Cincinnati November 26–29. The three—WHCRI, Illinois and Utah foundations—were examples of groups convertible to PSROs.

HEW to Name PSROs

It is urgent that WHCRI member groups meet now. During the next year, the Secretary of HEW must designate PSRO areas (of 300 or more physicians). He then will enter PSRO agreements with qualified organizations in those areas. The HEW Secretary can give the PSRO as much or as little latitude as he wishes.

In Wisconsin it might be possible for the whole state to be considered as a single PSRO area. If this happens, WHCRI could become the state's PSRO organization.

When it was started a year ago, WHCRI was designed as a peer review liaison body among professions and between professions and the public. It is already doing one PSRO-type job for the State Department of Health and Social Services (DHSS). On-site, independent medical reviewers are looking at Medicaid patients in state institutions for the mentally retarded — Central Colony, Northern Colony, and Southern Colony. WHCRI also has agreed to review Medicaid patients in Wisconsin nursing homes for the DHSS.

More Public Members

As interest in WHCRI grows, additional professional groups are becoming interested in participating in WHCRI. WHCRI's bylaws are now being studied for possible revision. In October the WHCRI board approved adding three public members to the board for a total of four.

As a founder of WHCRI the State Medical Society is urging all county medical societies to form peer review committees or to have them in dis-

continued on next page

Alert to Members!

DEADLINES for 1973 ANNUAL MEETING

Events

January 25
Resolutions for the House of Delegates due in Secretary's office

February
Early publication of the *Wisconsin Medical Journal* with inclusion of major portions of the Annual meeting program and summaries of the resolutions

March 24
Council meeting

March 25–26–27
House of Delegates sessions

March 26–27
Scientific Program

Dr. Goldstein Named to BC Hospital Rate Review Committee

The State Medical Society will have a representative on the 16-member Blue Cross hospital rate review committee. David N. Goldstein, MD, Kenosha, was appointed by the Chairman of the Society's Council, Eugene J. Nordby, MD of Madison. This procedure was approved by the Council at its last meeting, November 11.

The committee is charged with reviewing rate increase requests and deciding to accept or reject them. The committee's decisions are subject to appeal.

Nine of the committee members are members of the Blue Cross board. Other members are the president of Blue Cross, the executive director of the Wisconsin Hospital Association (WHA), and one appointee each selected by the WHA board of trustees, the Wisconsin Conference of Catholic Hospitals board of trustees, the Governor, and The Medical Society of Milwaukee County.

Other Council actions on November 11 that are not covered elsewhere in this GREEN SHEET include:

- Henry Veit, MD, Milwaukee, approved as the new chairman of the Division on Nervous and Mental Diseases.
- Joint billing for membership in WISPAC and the State Medical Society approved beginning with the 1973 statements mailed this month. WISPAC membership is voluntary.
- A number of proposed changes in the Society's Constitution and Bylaws reviewed. A hearing will be held at the 1973 annual meeting at which commission and committee chairmen are encouraged to tell how the Society can better help the committees with their work.
- Drafting of two pieces of legislation was approved. One would give immunity from civil suit to members of peer review committees. The other would make the review confidential. The public could have access only to statistics on the review without any identification of the providers or facilities reviewed.
- A report on the 1972 Wisconsin Work Week of Health was accepted. Questionnaires were sent to all physicians who attended the meetings last September in Madison, Milwaukee, Appleton, Wausau, La Crosse, and Rice Lake. About half of those polled responded. All respondents found some value in the conferences, which dealt with legislation, peer review, and the Governor's Task Force. Almost all wanted another such conference next year.

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EDITOR: Carol Davenport, Public Information Director, State Medical Society of Wisconsin.

PSRO continued

tricts serving several counties. The aim is implementation of WHCRI throughout the state.

The Council stressed this at its November 11 meeting and also:

. . . urged the Wisconsin Hospital Association to recommend to its member hospitals that their respective utilization review programs function within the WHCRI framework.

. . . recommended to the WHCRI Board of Directors that it consider making any adjustments necessary to be the statewide PSRO.

. . . requested the Council Committee on Peer Review to study the issue of PSRO in Wisconsin and its relationships with WHCRI.

The Council also adopted a statement outlining its position on the PSRO concept as a whole. It said it *agreed* with these PSRO concepts:

. . . Quality of medical care may only be evaluated by peer review.

. . . Peer review should be accomplished on as broad and integrated a spectrum of discipline as is practical.

. . . Peer review activities (programs) must develop in a manner that will include state and federal programs of financing health care.

The Council *lauded* these PSRO requirements:

. . . Review should be done with broad practitioner participation.

. . . Those engaged in the review process should be rotated periodically.

. . . Peer review programs should be publicized to assure public knowledge and understanding.

The Council said PSRO is consistent with the Committee on Peer Review and WHCRI in its encouragement of pre-admission review and the use, when the medical needs of the patient can adequately be served, of more economical alternative facilities.

The Council said, however, that because PSRO gives the Secretary of HEW substantial regulatory power, there is "the real possibility that regulation may respond unduly to the financial exigencies of a given moment rather than to the needs for health care quality. The result might diminish the exercise of independent professional judgment which is so essential to proper patient treatment. In this area, the State Medical Society and the AMA must be alert and willing to exercise constructive leadership, not merely critical protest, in seeking to assure the development of a sound peer review program."

The AMA sounded much the same note at its PSRO conference in Cincinnati. It decided to abandon its long opposition to PSRO and form a task force to work with the Secretary of HEW in setting the guidelines for regulation. Because the law has left the HEW Secretary so much leeway in how PSRO will work, the makeup of these guidelines is crucial.

Governor's Task Force—Politics by Psychology?

How psychology is used to handle the politically explosive issue of health care was outlined by Darold Treffert, MD, Fond du Lac, at a November 10 State Medical Society conference. An example of "psychopolitics" is the Governor's Health Task Force, Dr. Treffert said.

He called the Task Force "a veiled, non-political means to reach and justify a political end." That's what psychopolitics is all about, he said.

Dr. Treffert "analyzed" the "game plan of psychopolitics" for physicians in comprehensive health planning who attended the meeting in Madison. Its "six swift moves" are: the premise of finding a "better way of doing things"; appointment of task force members; public hearings; the angry and defensive response of the system under scrutiny; the task force report; and what happens to the task force report in the hands of the "psychopolitician."

Speech to be Printed

Dr. Treffert, a psychiatrist and superintendent of Winnebago State Hospital, provoked considerable discussion at the meeting over his "psychopolitical" analysis. (The text of his speech will be printed in full in an upcoming issue of the *Wisconsin Medical Journal.*)

In particular, Health Task Force vice-chairman Ben Lawton, MD, Marshfield, saw the term psychopolitics as "unfortunate" because "it implies something evil or underhanded. Politics *is* the art of influencing people to your way of thinking. Politics is *not* dirty and physicians had better get into it," Dr. Lawton said.

George Handy, MD, state health officer, also disagreed with Dr. Treffert. He said the Task Force's goal "is to pose the problems so that the Legislature will not be able to avoid them."

Public Has Responsibility

He said the public needs to be convinced of its own responsibility in health care. "If the public wants health and they want to spend money on resources, the profession is going to go along with it," Dr. Handy said. But he said comprehensive health planning cannot be imposed on people—it must come from the local communities.

MDs Ben Lawton and John Hirschboeck and Robert Purtell (left to right) spoke at the State Medical Society's conference on comprehensive health planning November 10.

Dr. Treffert

At the meeting, John Hirschboeck, MD, Milwaukee, described the relationship of the regional medical programs (RMPs) to comprehensive health planning. He said both have political overtones, consumer participation, and government money and both are trying to do what is best for the state.

Dr. Hirschboeck said the RMP's concern has shifted from heart, cancer, and stroke projects. Today RMP's mission is "to help the providers of health services improve their capability" by working in such areas as continuing education, collaboration of health professions, and quality assurance. Dr. Hirschboeck is coordinator of Wisconsin RMP.

WRMP Grant to WHCRI

Earlier this year WRMP gave $25,000 to help Wisconsin Health Care Review, Inc. (WHCRI), begin operation. (WHCRI was formed by the state medical, dental, and hospital associations as an interdisciplinary peer review and quality control organization.) Other WRMP grants in this area include: a study of the quality of outpatient care at the Marshfield Clinic; an appraisal of patient care in hospitals by Thomas Meyer, MD, Madison; and a set of guidelines for open heart surgery (published in the August 1972, *Wisconsin Medical Journal*).

Legislators Polled on MD Shortage

State legislators are being polled by the State Medical Society on Wisconsin's physician shortage. A letter and questionnaire on the problem went out this month with copies to presidents of county medical societies in each legislator's district.

Legislators were asked if:

- ...There are enough physicians in their area;
- ...Specific specialties are needed in their area;
- ...Any area in their district is not adequately served by physicians;
- ...Better transportation could improve any physician shortages in their district;
- ...Allied personnel such as physicians assistants and former medical corpsmen could fit into the medical delivery system.

Legislators were encouraged to comment on the physician shortage problem and to talk about it with the county medical society presidents in their district.

The questionnaire was approved by the Council at its last meeting November 11. The letter was signed by all 12 members of the State Medical Society's Special Committee on Shortage of Physicians.

Members are: R. T. Ragatz, Madison, chairman; T. A. Duckworth, Wausau; Sen. Fred A. Risser, Madison; Rep. F. James Sensenbrenner, Jr., Shorewood; and

MDs H. C. Pitot, Madison; E. J. Lennon, Milwaukee; S. E. Sivertson, Madison; E. A. Bachhuber, Milwaukee; G. J. Derus, Madison; J. H. Wishart, Eau Claire; W. R. Manz, Eau Claire; and J. W. McRoberts, Sheboygan.

David Carley (standing, left) addresses the final meeting of the Governor's Health Planning and Policy Task Force of which he is chairman. In November the Task Force readied its final report for publication. (Photo courtesy of Wisconsin Regional Medical Program)

FINAL REPORT READY

Abortion and Health Commission Cause Dissents in Task Force

Two months behind schedule, the labor pains of the Governor's Health Planning and Policy Task Force have finally ended. After 20 months of gestation, the Task Force has produced a hefty report of over 1,000 pages.

David Carley, Madison, chief of the report's 45 procreators, has expressed confidence that the fledgling volume will be well received in the state. It is scheduled to go on display sometime this month.

Not all Task Force members are happy about everything in the report. Four dissenting reports on various subjects were filed at the Task Force's final meeting on November 17. These four dissenting reports are included as part of the Task Force's final report.

Health Services Commission. State Medical Society Secretary Earl Thayer's dissenting opinion called the three-man Health Services Commission (see November GREEN SHEET) "the least desirable of several approaches to public accountability of providers and facilities." He also said it is unnecessary, citing these reasons:

ONE. It is not required for a certificate of need program. This can be administered by the areawide ("B") and statewide ("A") comprehensive health planning agencies.

TWO. It is not needed for institutional licensing. This is currently done by the Division of Health.

THREE. It is unnecessary for quality assurance. Wisconsin Health Care Review, Inc., created by the state's professional groups for physicians, hospital administrators and dentists, has already started this work and appears able to do the job.

FOUR. It will duplicate institutional rate review. A joint Blue Cross and Wisconsin Hospital Association program is already under way.

These four points cover all the proposed responsibilities of the Health Services Commission.

Mr. Thayer also said physicians should not be included in the certificate of need program as proposed by the Task Force. He said no other state does this and it will discourage physicians from coming to Wisconsin.

George Handy, MD, Madison, State Health Officer, and Barbara Shade of the University of Wisconsin, Madison, Department of Educational Psychology, added their signatures to Mr. Thayer's report.

Controversial Health Services. Milwaukee Attorney Dennis Purtell's minority report took issue with one of the "Guidelines for an Acceptable Health Care System" approved by the Task Force. That guideline supported access to "certain health and health related services" which "are viewed as socially or morally controversial." He said this could be interpreted as support of abortion on demand and euthanasia. The Task Force turned down his request to delete the statement. Instead, Madison Alderwoman Susan Kay Phillips and Robert Durkin, Vice-President of the Milwaukee County Labor Council, drafted a pro-abortion minority report. It supported "legalization of abortion and legal availability of birth control measures to all." The Phillips–Durkin statement got signatures of 20 other Task Force members, and Mr. Purtell got three others.

Developmental Disabilities. A minority report by John Martin, Assistant Director of the Institute of Governmental Affairs at the University of Wisconsin Extension, objected to including services for the developmentally disabled in the programs to be dealt with by "community services boards." According to a Task Force recommendation, county or multi-county boards would administer state monies coming into their areas to provide services for mental illness, alcoholism and other drug abuse, and developmental disabilities. Prof. Martin said "systems designed to serve the needs of the mentally ill in Wisconsin have historically failed to recognize, comprehend, and respond to the problems of the developmentally disabled and their families."

Prof. Martin also filed a "memorandum of reservation"

continued on next page

Hospital Discharge Survey Set by State Division of Health

Next year selected hospitals around the state will be asked by the State Division of Health for information on the patients they discharged in March and September.

The Division is updating 1967–68 information which has been widely used by health providers and agencies. This includes patient data, frequency and outcomes of diseases and conditions, use of surgery and other significant procedures and hospital utilization, including both geographic and administrative patterns.

The State Medical Society of Wisconsin has endorsed the survey as well as the Wisconsin Hospital Association, Wisconsin Health Care Review, Inc., Wisconsin Regional Medical Program, Comprehensive Health Planning, and the Medical College of Wisconsin.

The data will undoubtedly be important in the work of Wisconsin Health Care Review, Inc., a non-profit corporation for peer review formed a year ago by the State Medical Society, Wisconsin State Dental Society, and Wisconsin Hospital Association.

Results of the survey will be issued in a series of reports directed toward different types of users. The reports will be by such indicators as hospital size, state district, patient age, physician specialty, and the like. Individual patient and physician identity will be protected.

Only short-term general hospitals will be surveyed. Some results of the March survey are expected to be available before September.

TASK FORCE continued

about the Health Policy and Program Council (HPPC). The Task Force has recommended that the HPPC become a permanent body with broad responsibilities (see November GREEN SHEET). Prof. Martin questioned the Council's accountability and said the Task Force had not been specific enough about how the Council would be organized and administered.

All Task Force members agreed with a recommendation by Ald. Phillips that the final report "reaffirm the right of each Wisconsin citizen to health care."

Alcoholism in Industry

One recommendation which had been lost in the shuffle was passed at the Task Force's last meeting. It called for development of alcoholism treatment in industry. It said alcoholism should be classed as a disease by employers so that it would qualify for sick leave. It also called for "a publicly stated company policy on alcoholism."

Also at the final Task Force meeting, three additional items were referred to the HPPC for action. One focused on the need for expanded residencies in the state, especially for family planning. The HPPC was asked to consider requesting a statewide conference on family practice to be called by the Governor. The meeting would involve the Wisconsin Regional Medical Program, the Wisconsin Academy of Family Physicians and the two medical schools.

Another group of items was sent to the HPPC at the request of Task Force member Barbara Brown, Chairman of the Department of Nursing at Milwaukee's Alverno College. All touched on nursing. Specifically, these were requests that nurses: be used as health educators; be supervisors in skilled nursing homes; and be studied for a role in mental health. Mrs. Brown also asked that care be taken in experimenting with institutional licensure and that the Task Force's material on nursing be reworked because it is "not comprehensive and is somewhat misleading."

The third item referred to the HPPC dealt with health care services to correctional populations. Paul Glunz, MD, Beaver Dam, requested that special attention be given to this problem in light of a Fox Lake inmate's death last summer from an asthma attack.

Doctor, is your wife a member or member-at-large of the Woman's Auxiliary to the State Medical Society of Wisconsin?

If not, please urge her now to join her county auxiliary or to join or rejoin as a member-at-large (see application below). The Auxiliary needs her support and is only as effective as its membership's participation in assisting the Medical Society physicians in their aims, goals, and delivery of the best possible health care for all. Support your wife in a decision to join with the Auxiliary.

MRS. ROBERT JOHNSTON (Dolores)
President-elect, Woman's Auxiliary
to the State Medical Society of Wisconsin

MEMBERSHIP APPLICATION BLANK

for Members-at-Large

Name _____

Address _____

City _____ State _____

County _____ Zip Code _____

Members-at-Large membership dues: $6.00 ($4.00 to National, $2.00 to State). Check to: Woman's Auxiliary to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Family Practice Program OK'd for Medical College

Residents are now being recruited for a new family practice residency at the Medical College of Wisconsin (MCW). There will be openings for four residents when the program begins in July. The three-year program is expected to have a maximum enrollment of 12 residents.

MCW received approval of the program in late September from the national Residency Review Committee for Family Practice. The program is now looking for a full-time director, who must be a physician board certified in family practice.

MCW has been working for two years with the Wisconsin Academy of Family Physicians in planning the residency program. The accreditation committee that approved its plans represents the American Academy of Family Physicians, the American Board of Family Practice, and the Council on Medical Education of the American Medical Association.

According to Lawrence V. Perlman, MD, acting director of the program, residents will train in two settings. The principal one will be Milwaukee County General Hospital, the Medical College's main teaching hospital. The other will be the Downtown Medical and Health Services Center, housed in remodeled former facilities of the old Milwaukee County Emergency Hospital.

The Center now houses ambulatory medical and health services. The family practice residency will base its Model Family Practice Unit there until 1974, when it will move to permanent quarters adjacent to Milwaukee County General Hospital.

In-hospital rotation at the County Hospital will include the departments of medicine, pediatrics, surgery, gynecology and obstetrics. The residents will apply skills learned in these specialty disciplines in their work with patients and families assigned to them at the Model Family Practice Unit.

Medicine receives heaviest emphasis in the rotation. Residents will spend 14 months in that department, eight months each in pediatrics and electives, and two months each in the other specialties.

At the Model Family Practice Unit, residents will be given responsibility for a panel of families on a round-the-clock basis. First year residents will spend one day a week at the model office; second year residents, one and one-half days; and third year residents, two days. Residents are expected to develop a data base for each family member, formulate a plan of action, and provide continuing care.

Administratively, the residency is within the family medicine section of the College's department of medicine. Family practitioners are being recruited to this section. The Medical School has two full-time positions available to the program. The family physicians will be primarily in charge of residents' experiences in the Model Family Practice Unit. Residents will also spend time with specialists as they rotate through the various departments.

According to a brochure the Medical College is preparing on the program, it "is designed to emphasize ambulatory care, continuity of patient care, and preventive medicine." Training emphasizes both specialty disciplines and the social, economic, and psychological aspects of family health care.

The three-year program is open to senior medical students. Interns may apply for the last two years of the program.

70-Year-Old Doctors Get Break in Dues

The Society reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classification can be arranged.

National Health Educator Visits Medical Museum

Bruno F. Gebhard, MD (above), nationally known health educator, in early October visited the Museum of Medical Progress in Prairie du Chien as a guest of the State Medical Society's Charitable, Educational and Scientific Foundation (CESF). His recommendations will be presented to the CESF Executive Committee at its next meeting. Dr. Gebhard is director emeritus of the Cleveland Health Museum, the first health museum in North America.

Unique 20-Ft Sculpture of Medical Instruments to Be Built at Museum

A unique sculpture composed partly of medical instruments is being planned for the Museum of Medical Progress in Prairie du Chien.

The free form outdoor sculpture will be 20 feet high and stand on the lawn in front of Stovall Hall of Health. The base for the sculpture, a 24 foot cement mall, has already been poured and work is scheduled to begin on the sculpture in January. All work will be done on the spot in a temporary shelter built for the project. Unveiling of the finished sculpture is expected in May.

Two Prairie du Chien artists are working on the sculpture, to be made from a huge supply of used medical instruments donated over the years to the State Medical Society's Charitable, Educational and Scientific Foundation (CESF).

Gerald Riness is handling design of the sculpture and David Myers, a metal sculptor, will put the pieces in place. Mr. Rincss has been retained as the Museum's artistic consultant.

Theme of the sculpture is to be a tribute to medical achievements of the past and present. Anyone wishing to contribute used medical instruments or any type of metal pieces related to medical practice for use in the sculpture is invited to do so. Contact CESF for further information.

The Woman's Auxiliary to the State Medical Society is organizing a campaign to raise money for the sculpture project as well as for new Museum exhibits. Contributors will be able to designate physician memorials on benches to be placed around the sculpture.

Contributions to the project are tax deductible, as are all contributions to CESF, which owns and operates the Museum. Physicians can check off a contribution to CESF on their State Medical Society dues statement, mailed earlier this month.

Prairie du Chien artists David Myers (left) and Gerald Riness look over medical instruments they will use in a metal sculpture planned for the Museum of Medical Progress.

CESF Sponsors History of Medicine Contest

Two first prizes of $250 and two second prizes of $150 will be awarded to college graduate and undergraduate students in this year's "History of Medicine" contest sponsored by the State Medical Society's Charitable, Educational and Scientific Foundation (CESF).

The awards will be given for the best research paper dealing with any aspect of the history of medicine in Wisconsin.

Last year winning papers dealt with pioneer physicians and Wisconsin hospitals. Examples of other possible topics include Indian medicine, medical school history, military medicine and medical research.

Papers should be typewritten and a maximum of 3,500 words with appropriate bibliography.

Last year's winning paper by Dennis H. Phillips, entitled "Women in Nineteenth Century Wisconsin Medicine," appeared in the November issue of the *Wisconsin Medical Journal.*

Those who plan to submit a paper should notify CESF before January 1, 1973. Papers must then be completed and submitted before March 1, 1973. Graduate and undergraduate papers will be judged as separate categories by a CESF committee.

SMS committees *in action*

Materials on Chiropractic. Ad Hoc Committee on Chiropractic, August 3, agreed that informational materials on chiropractic should be prepared for distribution to libraries, schools, newspapers, and voluntary health agencies.

MDs and Chiropractic. Ad Hoc Committee on Chiropractic, August 3, agreed that the ethical ban on physicians professionally associating with or addressing chiropractic groups should be known to the membership.

Physician Immunity. Commission on Public Policy, September 25, asked that the State Medical Society give consideration to initiating legislation which would provide immunity from suit for physicians who serve on duly appointed hospital or medical organization committees.

Medical Practice Act. Commission on Public Policy, September 25, asked that the Ad Hoc Committee on the Medical Practice Act review the Medical Practice Act, particularly regarding flexibility in issuing temporary licenses to practice in the state.

Teaching Program on Detoxification. Division on Alcoholism and Addiction, October 4, indicated its desire that funding be found for a teaching program on detoxification procedures. Funds are needed for such things as travel and faculty time.

SMS Hot Line

WISCONSIN HEALTH CARE REVIEW INC., will have an increased number of public representatives on its board of directors. The increase was approved at that board's meeting October 5. Several potential public representatives are now being contacted.

CONTINUING MEDICAL EDUCATION is a requirement of membership in the Oregon Medical Association (OMA). However the requirement has caused less than a dozen of OMA's approximately 2,000 members to leave the group. The OMA program was described along with approaches in other states to peer review, self-assessment and accreditation of graduate educational programs at a Chicago program October 24-26. Three Wisconsin physicians represented the State Medical Society's Commission on Scientific Medicine at the program. They are Drs. S. E. Sivertson, Madison, Bradley G. Garber, Osseo, and E. O. Hirsch, Milwaukee. It was the Third National Conference of State Medical Association Representatives on Continuing Medical Education.

PHYSICIANS REAPPOINTED by the Governor to the Council on Highway Safety are James Weygandt, MD, Sheboygan Falls, and George Handy, MD, Madison. The Council advises the Governor and Coordinator of the Office of Highway Safety.

EXCESS MAJOR MEDICAL insurance being sponsored by the AMA has a toll-free information line in Chicago. AMA members with questions should call the administrator, Marsh & McLennan, Inc., (800) 621-0366.

State Moves Closer to Emergency Medical System

The Emergency Medical Service (EMS) system has moved a step further on its three-year agenda to improve emergency medical services throughout Wisconsin. Coordinators have been named across the state for setting up areawide councils to handle details within those areas. These advisory councils are the key to a successful EMS program.

EMS was started in July with a $1.2 million grant from the Wisconsin Regional Medical Program. Its aim is tieing together statewide communications networks and establishing training programs to meet on-site emergency situations across the state.

Nine coordinators have been named to organize the EMS councils. There is one for each of the eight areawide comprehensive health planning agencies ("B" agencies) in the eight state administrative districts. A ninth coordinator has been appointed for the Milwaukee urban area. The Milwaukee coordinator is to work closely with the southeastern Wisconsin "B" agency coordinator for EMS.

Council Concerns Differ

Because urban problems are different from rural problems, the urban EMS councils will have different concerns than the rural councils. The urban groups will need to consolidate the multitude of services in the cities. The rural groups will need to make sure the countryside has the service it needs.

Greater Milwaukee's EMS Council is being organized under the management of The Medical Society of Milwaukee County (MSMC). Mr. Michael McManus, MSMC's executive director, is EMS project director for the Milwaukee area. EMS project directors for the other areas of the state will be the directors of the "B" health planning agencies.

Each EMS council will have slightly different concerns, because each region of the state has different problems. One of the crucial tasks of the EMS councils will be to recommend how EMS vehicles in that area will be routed and dispatched.

Comfort and Joy!

WPS Blue Shield and our "family" would like to take this opportunity to express our sincere hope that you and *your* family will experience all the wonderful and exciting moods of the holiday season!

Especially at Christmas time, we'd like to offer our "thanks" for helping to make our job a little easier throughout the past year.

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COUNCIL MINUTES—State Medical Society of Wisconsin

MADISON, JULY 29, 1972

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 1:30 p.m. on Saturday, July 29, 1972, at the State Medical Society.

Voting members present: Doctors John J. Foley, Olsman, Nordby, Huth, Edwards, Smejkal, Mauthe, Dettmann, Rohde, Heinen, Lewis, Manz, Doyle, Egan, LaBissoniere, Williams, Pittelkow, Thomas J. Foley, Schmidt, Meyer, Past President Behnke, President Purtell, and Speaker Nereim.

Others present: President-elect Derus, Vice Speaker Hamlin; AMA delegates and alternates Bell, Collentine, Galasinski, Hildebrand, Twelmeyer, and Russell; Assistant Treasurer Quisling; Doctors Simenstad, Bein, and Headlee; Messrs. Thayer, Koenig, Brower, Reynolds, Maroney, Johnson, LaBissoniere, Brown, Kluwin, and Horton; Mmes. Anderson and Davenport; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Egan–Behnke, carried, minutes of the May 7 and 10, 1972, meetings were approved.

3. Oath of Office

Doctor Nordby administered the oath of office to John J. Foley, MD, councilor from the first district.

4. Review of House of Delegates Actions and Establishment of Priorities

The Council had been provided with a summary of House actions in May together with an indication of assignments of responsibility to staff to see that they are implemented. The Secretary reported that progress has been made as to many, and another report will be presented at the November meeting by which time it is expected that actions requiring specific activity not of a continuing nature will be completed or scheduled.

The Council also reviewed a statement of priority objectives for 1972–73 in the areas of scientific medicine and continuing education; public affairs; socio-economic medicine; and organization and administration.

On motion of Doctors Huth–Heinen, carried, these priorities were approved as follows:

Scientific Medicine and Continuing Education

1. Study and propose a role for the State Medical Society in continuing education programming in Wisconsin.
2. Participate actively and effectively in the development of the Wisconsin Emergency Medical Services program.
3. Conduct eight in-depth courses in 1972–73.
4. Evaluate and propose Society policy for continuing education (self-assessment, voluntary vs. mandatory continuing education requirement, relationship to peer review programs).
5. Prepare for and present Annual Scientific Program and House of Delegates sessions for March 25–27, 1973.

Public Affairs

1. Develop and present to the physicians and the public a "positive" legislative program for 1973.
2. Revitalize the county medical society public policy (legislative) committees and "key man" program.
3. Encourage county based WISPAC activity.
4. Conduct a public education program on chiropractic (implemented with a $10 per member dues assessment).
5. Participate in and provide leadership for physicians and the public with regard to the work and recommendations of the Governor's Health Planning and Policy Task Force.
6. Expand communications from the Society to the public concerning health care, medical economic matters, and scientific medicine.
7. Conduct the 10th Annual Wisconsin Work Week of Health.

Socio-Economic Medicine

1. Activate Wisconsin Health Care Review, Inc. in terms of becoming operational for ongoing peer review with health insurance carriers and governmental programs.
2. Develop functioning local or district medical peer review committees as integral parts of the SMS Committee on Peer Review to bring operating capability to WHCRI.
3. Conduct district meetings (to cover the state) relative to peer review, WHCRI, and the foundation concept.
4. Continue to provide guidance to county medical societies in the development of experimental health maintenance programs and similar projects involving comprehensive benefit protection for the public.
5. Study concepts of collective bargaining.
6. Studies of the Committee of Eight.

Organization and Administration

1. Continue study of SMS Constitution and Bylaws with view to clarification and modernization.
2. Improve SMS-county society-specialty society-membership communications.
3. Review councilor districting of SMS—committee appointed by President to report to the Council in November, for action by the House of Delegates in March 1973.
4. Secretary's office to obtain all resolutions for the Annual Meeting no later than 60 days prior to March 25, 1973, and send to delegates six weeks prior to the meeting; summaries to be printed in the February Green Sheet.

5. Report and Recommendations of AMA Delegation

Doctor Galasinski highlighted actions at the June AMA meeting which he said were well covered in the July 3 American Medical News. He also pointed out that the AMA had published summaries of resolutions and some reports in advance of the convention, which it was believed came about in large measure from action by the Wisconsin House of Delegates in May. The delegation asked that an expression of appreciation be sent the AMA.

He also noted the election as chairman of the AMA Council on Medical Service of W. B. Hildebrand, MD, who received congratulations from the Council.

Several matters were presented for advice or action by the Council:

A. North Central Conference

On motion of Doctors Behnke–Mauthe, carried, the Council accepted the recommendation that Wisconsin discontinue affiliation with the North Central Conference.

B. Recognition of Past AMA Delegates

The Council approved the recommendation that starting with E. L. Bernhart, MD, retiring members of the Wisconsin AMA delegation be presented with an appropriately engraved silver plate at Society expense.

C. AMA Long Range Planning and Development Council

There are several questions pending before this AMA Council which will be discussed at future AMA meetings and on which the delegation requested advice:

(1) On motion of Doctors Nereim–Behnke, carried, the Council recommended that Wisconsin continue to support the preservation of the AMA as a federation of state societies.

(2) The question of increased AMA input by specialty societies and other medical organizations, including the concept of proportionate representation, was tabled pending a further report from the delegation.

(3) Geographic representation on the AMA Board of Trustees
On motion of Doctors Lewis–Edwards, carried, the Council recommended continuation of the present method of at-large election of AMA trustees.

(4) Limitation of tenure of AMA Trustees
On motion of Doctor Behnke, seconded and carried, the Council recommended that tenure of AMA Trustees be limited to two three-year terms.

Discussion followed on the question of limiting the terms of delegates from Wisconsin to the AMA. On motion of Doctors Behnke–Mauthe, carried, this was referred to the Planning Committee for consideration in its review of the Constitution and Bylaws and for recommendation to the Council.

6. Governor's Health Planning and Policy Task Force

Mr. Thayer highlighted the contents of a special report prepared for the Council, officers and others, on the status of Task Force studies—a summary of what is anticipated from the various subcommittees, and any proposals that have reached a stage of adoption, final recommendation, or release for public discussion. He indicated that where State Medical Society policy exists on subjects under consideration this, of course, is made known within the Task Force. As other matters proceed toward finalization and report to the Governor, the advice of Society committees and the Council will be called upon and decisions made as to the manner in which the Society should make its position known in areas of disagreement with conclusions. The special report will be updated during the final months of the Task Force's existence.

7. Council Committee Reports

A. Executive Committee

(1) Committee of Eight

Doctors Purtell, Nordby and Behnke reported for information of the Council on the July 7 meeting of the committee of eight at which certain points of agreement were reached.

(2) Wisconsin Health Care Review, Inc.

The Executive Committee reported on progress as evidence by contracts between the Department of Health and Social Services and WHCRI for review of Title 19 patient care in the colonies and nursing homes; further that an individual has been employed and timetables established for the development of guidelines for the conduct of peer review to be submitted to the Council Committee on Peer Review and then to the WHCRI board. Also to be developed are screening criteria for carriers in the submission of cases for review.

The Council acted on the following recommendations:

On motion of Doctors T. J. Foley–Heinen, carried, the Council Committee on Peer Review was enlarged from the present ten members to include:

William L. Treacy, MD, Milwaukee
Thomas M. O'Connor, MD, Elm Grove
Robert F. Madden, MD, Milwaukee
Rocco Latorraca, MD, Wauwatosa
Robert B. Jachowicz, MD, Hales Corners
Francis N. Lohrenz, MD, Marshfield

On motion of Doctors Behnke–Smejkal, carried, the Council approved increasing the number of public representatives on the WHCRI board from one to three, such action to be forwarded to that board for concurrence.

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(3) County Society Sponsored Plans

Plans of various types are being proposed to or under consideration by county medical societies—"sickness care plans," foundations, HMOs, arrangements with clinics or hospital staffs.

On motion of Doctors Behnke–Heinen, carried, the Council approved the recommendation of the Executive Committee that the Secretary, with assistance of legal counsel as necessary, prepare a paper outlining the obligations and responsibilities of the county societies and the State Medical Society in these matters, including the role that WHCRI can play in such developments.

(4) Wisconsin Work Week of Health for Physicians in 1972

The committee reported it had approved plans for a series of six regional meetings in September which will be limited to legislative matters, including Task Force proposals, and health care review. The conference requested by the House of Delegates for physicians involved in area comprehensive health planning, also to include those associated with the Wisconsin Regional Medical Program, is planned for Friday, November 10, preceding the next Council meeting.

(5) Customary, Usual and Reasonable Fee Determination

The committee had held lengthy discussion of the fundamental right of a physician and his county society to establish what are believed to be reasonable fees, and the necessity for the solution of disputes to be maintained within the house of medicine.

On motion of Doctors Edwards–Meyer, carried, the Council approved the recommendation that the Executive Committee be designated to act as the mediating agency in resolving the dispute between the Medical Society of Milwaukee County and the other county medical societies in Wisconsin as to the establishment of customary, usual and reasonable fees.

(6) Appointments to AMA Councils and Committees

Individual councilors were asked to submit to the Secretary's office any nominees they might have, with pertinent biographical information on qualifications, for possible appointment to AMA councils and committees on which vacancies will occur at year-end.

(7) Redistricting Committee

President Purtell announced his appointments to the ad hoc committee to study redistricting, as requested by the House of Delegates, to consist of one member from each councilor district.

(8) Standing Committee Appointments

On motion of Doctors Egan–Mauthe, carried, the Council affirmed appointments by President Purtell to standing committees, as follows:

DeLore Williams, MD, West Allis, ex officio member of the Commission on Public Policy as chairman of the ad hoc committee on chiropractic

George A. Berglund, MD, Milwaukee, to a vacancy on the Commission on Scientific Medicine

John T. Goswitz, MD, Manitowoc, to a vacancy on the Committee on Cancer

B. Committee on Economic Medicine

Doctor Schmidt reported that the committee had received a report of experience with the Provident disability insurance program for members; has requested details of experience and coverages under the WPS program for further consideration; will study further the suggestion that travel accident benefit limits be increased, as well as proposals recently made to the Society in reference to services for members of an economic nature.

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C. Finance Committee

Doctor Dettmann reported that there were no deviations of consequence as between the budget and expenditures from the general fund; that preliminary discussions were held on a 1973 budget which it is anticipated will be completed by the November Council meeting.

The committee recommended that those physicians who had not yet paid the special assessment of $10 receive two more billings if necessary, and then be given the option to contribute instead to the CES Foundation.

This recommendation was approved on motion of Doctors Dettmann–Huth, carried.

D. Planning Committee

Doctor Manz reported orally on the morning's deliberations in reference to revisions of the Constitution and Bylaws. Chairman Nordby asked that all of its recommendations be presented in the form of amended articles or bylaws. The matter of reimbursement of physicians' assistants is also to receive further study by the committee.

8. Ad Hoc Committee on Chiropractic

Doctor Williams outlined the priorities established by this committee for utilization of the special assessment fund. His report was received with the Council's compliments.

9. Society Historian

On motion of Doctor Huth, variously seconded and carried, Leland C. Pomainville, MD, was reelected Society historian.

10. Academy of Medical History

The Academy, formerly a "Section" of the State Medical Society, presently derives its existence and authority from the Society Bylaws. Its activity is related almost totally to the collection, preservation, and display of medical artifacts and memorabilia, and particularly in support of the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien. It was suggested that as a practical matter the Academy is more closely related to the affairs of the CES Foundation which owns and operates the Museum, and therefore recommended that the Bylaws be amended to remove it from the immediate jurisdiction of the Society and be established as an integral part of the Foundation with the same basic purposes.

On motion of Doctor Egan, seconded and carried, this recommendation was approved for action by the House of Delegates.

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS TO THE COUNCIL—JULY 29, 1972

Operating results during the first six months of 1972 are most favorable. After satisfaction of all claim liability and administrative expenses, $970,000 was added to general reserves. The addition of 36,000 new persons to the WPS portfolio brings total persons covered to 436,730.

A new fee screen system was established effective July 1, resulting in 10 localities (instead of 62) for fee determinations on Medicare claims. This will provide more flexible fee ranges under the Medicare program, although the current price freeze will still limit increases.

On-site audits at the insistence of SSA were conducted involving 25 physicians. These audits included hospital records and "pattern of practice" questionnaires developed by SSA. Staff documented sufficient factual information to demonstrate the gross SSA statistics were misleading. There remain only 3 cases being questioned by SSA.

Based on a recent regional study of computer applications and costs of Medicare Part B Carriers, out of 4 states studied WPS had the lowest computer operating costs and could not benefit by centralizing its processing within a regional computer location. WPS offered the Blue Shield Plan of Milwaukee County its computer capability for their administration of Medicare Part B claims since NABSP had indicated Surgical Care's costs could be substantially reduced through use of other than the Blue Cross computer facility. This offer was declined by Surgical Care.

The Commission has referred contract administration questions to Council Committees. Payment for non-MD physicians' assistants, including the level of reimbursement, has been referred to the Planning Committee. Increasingly, services provided by physicians' employees (for example, psychologists and psychiatric social workers) are separately itemized and billed at rates comparable to those for services of the physician. The advice of the Society's Division on Nervous and Mental Diseases has been requested.

WPS has denied requested cash grants from two Southern Wisconsin Health Planning groups. The Commission and Council have previously denied on the basis that the Society, including its insurance program, is engaged in substantial planning activity through the use of its own cash and personnel resources, and could not ignore other areas of the State in contributing to two agencies.

Current status of House of Delegates projects assigned the Commission is as follows:

A letter to every organization providing health insurance coverage in the State, urging their early action to provide first-day health insurance coverage for the newborn, has been developed. This will be followed up, if necessary, with personal contact to implement the intent of Resolution L.

A brochure (requested by Resolution A) is available to physicians' offices, containing a message appropriate in those instances in which the Medicare allowance is less than the physicians' usual fee and the patient thus receives a billing for the unpaid balance.

The activity of the Governor's Health Planning and Policy Task Force is being carefully monitored. Assistance is being made available to them at their request to implement two proposals developed by WPS and endorsed by the Council. These involve action to improve the availability of health insurance coverage to the unemployed and uninsurable.

Through the WPS delegate to NABSP, Dr. D. N. Goldstein, protest was lodged with the National Association over release of information by them to the Associated Press that resulted in a widely distributed article on the subject of MD overcharging. The article was statistically inaccurate, and the Annual Session of Plans directed National Association staff to refrain from such releases in the future.

These matters and others continue to receive full-time attention on a monthly basis at meetings of either the Executive Committee or the entire Commission.

E. M. Dessloch, MD, *Chairman*
Commission on Medical Care Plans

11. Commission on Medical Care Plans

The written report of the Commission as distributed at the Council meeting appears on page 46.

12. Commission on Public Policy

Doctor Russell reported generally on the Commission's recent review of key legislative issues for the purpose of determining the Society's 1973 legislative program, including legislation to be introduced as a result of House of Delegates actions.

On kidney disease aid, the Commission believed that the Society should support in principle a program of state aid to supplement the cost of kidney disease treatment, and recommended that the Council reconsider its position that this program would be better handled as catastrophic care under insurance rather than by state financing.

In reference to creation of a Perinatal Health Care Authority, the Commission recommended that the Society continue its support of the concept of this legislation and that the Council give further consideration to the means of financing such a proposal.

It recommended further that the Society's position paper on "Health Manpower in Wisconsin in the 1970s" be updated and that items from this paper which can properly be considered for legislation be included in the 1973 legislative program. (This will be under review by the Special Committee on Shortage of Physicians.)

The Commission also reported plans for development of a Checkpoint program of legislative liaison by county medical society and Auxiliary representatives. Implementation will commence during the regional Work Week of Health programs.

No formal action was taken by the Council on the above recommendations.

13. CES Foundation

A. Student Loan Fund

On motion of Doctors Mauthe–Egan, carried, the Council approved the recommendation of the Foundation board that the original student loan trust fund of the Society, with a balance of $1,705, be contributed to the Foundation so that it is no longer a separate entity requiring separate accounting, auditing and reports.

B. Nonmedical Trustees

On motion of Doctors Mauthe–Edwards, carried, the Council approved four nominees, including one woman representing the public and one from the Auxiliary, subject to their acceptance of membership on the Foundation board of trustees.

14. Miscellaneous

A. Drug Abuse Survey

On motion of Doctors Behnke–Egan, carried, the Council endorsed a proposed survey by the state of appropriately selected physicians for the purpose of gathering data on the incidence of drug abuse.

B. AMA Survey of County Jails

On motion of Doctors Behnke–Mauthe, carried, follow-up of responses from within Wisconsin to an AMA survey including health conditions and services in county jails was referred to the Commission on State Departments.

C. Maternity Nurse Clinician Project of WRMP

On motion of Doctor Egan, seconded and carried, this proposed pilot project was referred to the Division on Maternal and Child Welfare for reaction on behalf of the Society.

15. Adjournment—5:10 p.m.

EARL R. THAYER
Secretary

Approved: Nov. 11, 1972
EUGENE J. NORDBY, MD
Chairman

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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 13, 1972

NEW MEMBERS

Almonte, Ricardo A., 216 Sunset Place, Neillsville 54456
Bartholmai, Jack R., 138 Front St., Beaver Dam 53916
Blevins, James W., P. O. Box 134, Juneau 53039
Cabaltica, J. B., 50 North Union St., Mauston 53948
Choe, Doug C., 152 South Locust St., Janesville 53545
Ericson, Huron L., 517 Melvin Ave., Racine 53402
Eschenbaum, E. G., Jr., 1004 Nina Ave., Wausau 54401
Fernandez, Pedro B., 1011 North 8th St., Sheboygan 53081
Goldman, Allan L., 2105 East Newport Ave., Milwaukee 53211
Goodman, Joseph J., 2110 East Glendale Ave., Milwaukee 53211
Herman, Stephen J., 614 First St., Wausau 54401
Hootkin, Lawrence A., 945 North 12th St., Milwaukee 53233
Ignace, Gerald L., 7400 Harwood Ave., Milwaukee 53213
Jasser, Mohamed K., P. O. Box 22, Appleton 54911
Kaupie, Robert C., 400 East Thomas St., Wausau 54401
Kropp, August D., 111 East Wisconsin Ave., Milwaukee 53202
Lane, Jack T., 5625 Washington Ave., Racine 53406
Larson, Carol A., 2714—14th St., Eau Claire 54701
Logan, Michael J., N1198 Lapham Peak Rd., Delafield 53018
Mahony, William M., 3120 South 30th St., Milwaukee 53215
Mundschau, Gerald A., 5757 West Oklahoma Ave., Milwaukee 53219
Parcon, Jose P., 120 North Main St., Iola 54945
Rietbrock, Michael J., 915 East Summit Ave., Oconomowoc 53066
Rodriguez, Generoso N., P. O. Box 98, New London 54961
Sather, R. Alan, 1200 North Center St., Beaver Dam 53916
Shillinglaw, John A., 103 West College Ave., Appleton 54911
Walker, Anthony G., 620 North 19th St., Milwaukee 53233
Whang, Ki Jun, 130 Warren St., Beaver Dam 53916

CHANGE OF ADDRESS

Banyai, Andrew L., 470 Third St., South, St. Petersburg, Fla. 33701
Barbo, Dorothy M., Hammond 54015
Borchardt, Ronald E., 5711 Francis Court, Greendale 53129
Brenneyan, Robert N., 9 George St., Greenfield, Mass. 01301
Burgess, Gordon F., Jr., 2105 East Newport Ave., Milwaukee 53211
Carnesale, Peter G., 5726 Gladeview Dr., Memphis, Tenn. 38117
Churchill, Bernard P., 9321 Briarwood Circle, Sun City, Ariz. 85351
Dimlich, S. Henry, 123 Wyoming St., Dayton, Ohio 45409
Feierstein, William E., 4823 West North Ave., Milwaukee 53208
Gingrass, Ruedi P., 700 North Water St., Milwaukee 53202
Grossmann, Erwin E., 155 E. Silver Spring Dr., Milwaukee 53217
Harris, Theodore A., 700 North Water St., Milwaukee 53202
Heath, Hunter, III, Box 486, Letterman General Hospital, Presidio of San Francisco, San Francisco, Calif. 94129
Hirschler, Charles W., 2817 Regent St., Madison 53705
Horwitz, S. Fredric, 13622 North Birchwood Lane, Mequon 53092
Johnson, W. Dudley, 7441 West Greenfield Ave., Milwaukee 53214
Jorris, Edwin H., 1300 N. Portofino Dr., Apt. 307, Sarasota, Fla. 33581
Jurevics, Ingrid E., 17050 West North Ave., Brookfield 53005
Kim, Soo Yun, 16 Steeplechase Dr., Racine 53402
Landstrom, Donald L., 1729 North 72nd St., Wauwatosa 53213
Levin, Jules D., 1530 West Spruce Court, Milwaukee 53217
MacMillan, David G., 2716 Upper Afton Dr., St. Paul, Minn. 55119
Maxwell, John W., Sr., 2266 North Prospect, Milwaukee 53202
Miranda, Warren L., 1113 Onstad Dr., Marshfield 54449
Piper, Philip G., 36 South Brooks St., Madison 53715
Richter, Joseph R., 2221 Valley Rd., La Crosse 54601
Servis, Lionel T., 2105 East Newport Ave., Milwaukee 53211
Sprague, Lindley V., 4705 County Trunk M., Middleton 53562
Thorpe, Robert F., P. O. Box 279, Manitowoc 54220
Tomkiewicz, Ralph E., 312—7th St., Racine 53403
Voet, Raymond K., 5000 Sheboygan, Madison 53705
Wiegmann, Otto A., 17050 West North Ave., Brookfield 53005
Yunus, Hafiz M., 836 North 12th St., Milwaukee 53233

DEATHS

Beglinger, Harold F., Marathon County, October, 1972
Koch, Herman C., Green Lake–Waushara County, Oct. 13, 1972
Llewellyn, Maxwell B., Rock County, Oct. 14, 1972
Scholter, Edmund A. W., Milwaukee County, Oct. 30, 1972
Parish, George A., Dodge County, Nov. 3, 1972
Rosenbaum, Francis F., Milwaukee County, Nov. 7, 1972 □

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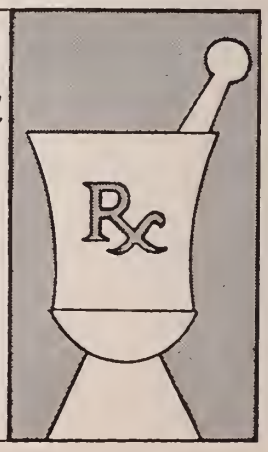

NEWS HIGHLIGHTS

Max Fox Preceptor Award Honors Dr. Kindschi

A longtime Monroe physician, Leslie G. Kindschi, MD,* was honored by the University of Wisconsin at the Green County Medical Society's annual dinner November 21.

Doctor Kindschi was presented the UW Medical School's Max Fox Preceptor Award for his long service to medical education. He is the third person to receive the award, which honors physicians throughout the state for their efforts in developing medical preceptorship in the state.

Dr. Kindschi

The program, pioneered in Wisconsin over 30 years ago, allows senior medical students at Madison to spend eight weeks with a practicing physician and helps to shape their medical careers. Students accompany the local doctor on his hospital calls, observe his hospital and office practice, and help the physician in some duties.

Doctor Kindschi was head preceptor in Monroe from 1948–1968 and over 120 UW medical seniors learned small town medical practice firsthand during that time. The University of Wisconsin Medical School preceptorship program operates in 15 Wisconsin communities. Eugene E. Eckstam, MD* at the Monroe Clinic, the current preceptor in charge there, assisted in making the arrangements to honor Doctor Kindschi.

Top administrative officials from the University, the medical school and the Wisconsin Medical Alumni Association, which sponsors the preceptorship award, were on hand for the presentation, which was held at the Monroe Country Club as part of the County Medical Society's annual dinner. Emeritus Dean William S. Middleton, MD,* who headed the medical school for 20 years, was a member of the party coming from the University.

A Madison native, Doctor Kindschi received his BA degree from Wisconsin, spent his first two years of medical school at UW and graduated from Harvard with an MD degree in 1935. A fellowship at the Cleveland (Ohio) Clinic followed his internship at Cleveland Hospital. He then served a three and one-half year internal medicine fellowship at the Mayo Clinic and spent another year there as junior appointee.

Doctor Kindschi joined the young Monroe Clinic in 1941 after a short time in Madison and in 1943 went on active duty with the Navy during WWII. Lt. Cmdr. Kindschi returned to Monroe in 1946. He was chief of medicine at the clinic and St. Clare Hospital from 1957–1967, active with the State Medical Society of Wisconsin and its JOURNAL, as well as the Monroe Board of Education. His numerous medical affiliations include president of the Wisconsin Society of Internal Medicine.

Previous recipients have been MDs Merritt L. Jones, Wausau, and Peter A. H. Midelfort, Eau Claire.

Outagamie County Health Center Discussed

Mr. Alvin Woehler, Outagamie county executive of Appleton, addressed the Outagamie County Medical Society, November 16, on the subject "Future of the Outagamie County Health Center."

Discuss Psychiatric Commitment Procedures

Members of the Jefferson County Medical Society heard Mr. Eberhart of Jefferson discuss Wisconsin's law on psychiatric commitment procedures, November 16, at the Countryside Home and Hospital in Jefferson.

PHYSICIAN BRIEFS

Donald M. Willson, MD*

. . . Milwaukee, a member of the Milwaukee Medical Clinic recently announced that MDs John D. Agayoff, Jr., Brenton H. Field, Jr., and Maynard D. Poland,* all members of the clinic, were certified by the American Board of Internal Medicine.

Edward C. Schmidt, MD*

. . . Milwaukee, recently accepted the Clinical Directorship at the Milwaukee County Mental Health Center–South Division on a part-time basis. He also is engaged in private practice in Milwaukee.

Darald A. Treffert, MD*

. . . superintendent of the Winnebago State Hospital, recently was the keynote speaker at the 19th annual University of Wisconsin—Whitewater Guidance Conference held in Whitewater. Doctor Treffert discussed schools and mental health in a speech entitled "Oval Souls—Round Planets."

Norman F. Deffner, MD

. . . Wausau, recently became associated with William C. Miller, MD* as an associate in dermatology. Doctor Deffner graduated from the University of Wisconsin Medical School in 1968 and served his internship at the Gundersen Clinic and La Crosse Lutheran Hospital. His residency was spent at the Mayo Clinic, Rochester, N.Y.

Michael Thimmesch, MD

. . . Minocqua, recently became associated with Robert Smith, MD* in the practice of radiology. Doctor Thimmesch graduated from Marquette University School of Medicine in 1966 and interned at St. Joseph's Hospital, Milwaukee. He served two years with the United States Air Force in Tucson, Ariz., and spent three years of residency training at St. Joseph's Hospital before joining Doctor Smith.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Help! Do You Have Medical Equipment for Health Service Corps Physician?

Dr. Michael Reinardy chats with Joan Fish, left, a member of the health committee with which he works, and Lynn Skenandore, Menominee County librarian, in the library to which he donated some of his books more than five years ago when he first became interested in practicing medicine in Menominee County. (GREEN BAY PRESS–GAZETTE Photo)

The Health Service Corps physician in Menominee County is badly in need of medical equipment and supplies. He has called upon the State Medical Society for help. Here is a list of the items he needs: EKG machine, autoclave, retinoscope, microscope, lab equipment, hemochromometer, proctoscopic table, emergency supplies, hemostat, equipment for minor surgery, forceps, ear syringe and other instruments, loupe, tonometer, and surgical lamps.

Any physician or physician's widow who might be in a position to help Doctor Michael Reinardy also will be helping the Menominee residents. Doctor Reinardy has stated that he prefers to remain "on a salary basis and put any profits back into health care, scholarships, etc., for the benefit of the community."

A donation can be handled through the Society's Charitable, Educational and Scientific Foundation as a tax-deductible item. Inquiries may be made to: Terrance S. Goerne, CES Foundation, Box 1109, Madison, Wis. 53701; or by phoning (608) 257–6781, ext. 289.

* * *

From the GREEN BAY PRESS–GAZETTE, the following story is related:

Doctor Reinardy started his practice in Menominee County July 17 through an arrangement with the National Health Service Corps (NHSC). A native of Janesville, Doctor Reinardy received his MD degree from the Marquette University School of Medicine in 1966. He interned at St. Mary's Hospital in Milwaukee, and practiced four months at the Ivanhoe Medical Center there before entering the U.S. Army as a flight surgeon.

Three years later, after attaining the rank of major, he left the Army and began a residency and family practice at Hennepin County General Hospital in Minneapolis in July 1970. He came to Menominee County from that position.

Doctor Reinardy had been considering opening a practice in Menominee County since 1967 when he first made contact with its people. He seized the opportunity when the NHSC announced that it would sponsor a doctor in the county.

"As far as I'm concerned," Doctor Reinardy asserts, "I'm here for life."

Under the terms of the NHSC agreement, the new doctor will be sponsored for at least one year. This means that his salary, and that of a nurse, a community health worker, and, hopefully, a dentist, will be paid jointly by the NHSC and the community.

Doctor Reinardy says that the NHSC estimates its cost will be $45,000 per year. The community's share will be in the form of providing facilities, equipment, maintenance, expendable supplies and utilities.

Patients are charged on a fee schedule. Those certified as unable to pay, as determined by the Menominee County Social Services Director, will not be required to pay for medical treatment.

Profits or losses in revenue are shared by the NHSC and the community according to the percentage of their respective contributions to the program. Doctor Reinardy himself is paid a fixed salary and does not profit from the fees collected.

Operating out of Neopit Community Center, Doctor Reinardy has continued cooperation with Volunteers for Inter-tribal Medicine, a group which flies doctors into Menominee County and the Stockbridge–Munsee Reservation nearby, on a part-time basis.

He says that area doctors, too, have been providing part-time medical service which he continues to welcome. □

George T. Anast, MD

. . . Minocqua, chief of orthopaedics at Lakeland Memorial Hospital, Woodruff, recently directed a two-day national forum on the future of hospital emergency departments in Chicago. The meeting, entitled "The Future of Emergency Medical Services in America," consisted of lectures, seminars, and workshops on the organization, operation and administration of the emergency department. Doctor Anast is secretary of the Academy's Sub-Committee on Emergency Room Care.

Robert E. Whiteway, MD*

. . . La Crosse, recently joined the medical staff of the West Salem Clinic. He graduated from Northwestern University School of Medicine in 1946 and did general practice and industrial medicine in the Chicago area before becoming assistant medical director for the Blue Cross and Blue Shield plans of Illinois. Prior to joining the West Salem Clinic, Doctor Whiteway had been associated with the Gundersen Clinic for eleven years.

Everett A. Beguin, MD

. . . Monroe, recently became associated with the Monroe Clinic medical staff. He graduated from the University of Wisconsin Medical School and served his internship at Rockford Memorial Hospital. Doctor Beguin took four years of residency at Barnes Hospital which is affiliated with Washington University in St. Louis. Prior to joining the Monroe Clinic, he completed two years of service in the United States Air Force.

William S. Middleton, MD*

. . . Madison, delivered the keynote address at dedication ceremonies for the new research wing of the Washington, D. C. VA Hospital. Doctor Middleton, dean emeritus of the University of Wisconsin Medical School and former chief medical director of the Veterans Administration, is now VA Distinguished Physician.

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PHYSICIAN BRIEFS . . .

Ralph B. Pelkey, MD*

. . . Pound, recently was honored at a testimonial dinner for his 35 years of service to the area. Doctor Pelkey graduated from the University of Wisconsin Medical School and served his internship in Milwaukee. He practiced in Coleman for three years and then moved to Pound. In 1953 he constructed a building adjacent to his home which is called the Pound Medical Clinic.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1972

1	SMS Committee on Occupational Health
2	SMS Committee on Medicine and Religion
2	Madison Area Radiologists
6	Dane County Medical Society Insurance Advisory Committee
7	Madison General Hospital Surgical Staff
7	Madison Urological Society
7	Madison Anesthesiology Society
7	Dane County Medical Society Board of Trustees
8	SMS Ad Hoc Committee on Chiropractic
9	Madison Academy of Internal Medicine
9	SMS Ad Hoc Committee on Districting
9	Board of Directors, Wisconsin Association of Professions
10	Comprehensive Health Planning Conference
10	Executive Committee of SMS Council
11	Planning Committee, Committee on Economic Medicine, and Finance Committee of SMS Council
11	AMA Delegates Caucus
11	SMS Council
14	Board, Woman's Auxiliary to the State Medical Society
16	SMS Commission on Scientific Medicine
16	Executive Committee, SMS Section on Ophthalmology and SMS Division on Vision

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

NEWS HIGHLIGHTS . . .

Wisconsin Chapter—ACS Met in Milwaukee

The Annual Meeting of the Wisconsin Chapter of the American College of Surgeons was held Saturday, November 11, at Milwaukee County General Hospital in Milwaukee. The program subject was "Approaches to the Problem of Acute Trauma."

Program participants and their topics were as follows: P. Richard Sholl, MD,* Janesville, President, Wisconsin Chapter—ACS, moderator; John L. Doyne, Milwaukee, County Executive, welcome; David R. Boyd, MD, Chief, Division of Emergency Medical Service and Hospital Service, Illinois Department of Public Health, "A Statewide Approach to the Treatment of Acute Injury-Trauma Centers;" Jerome J. DeCosse, MD,* Professor and Chairman, Division of Surgery, Medical College of Wisconsin, and Staff, surgical grand rounds—"The Approach to Trauma at Milwaukee County Hospital" with presentation of cases; Dennis Purtell, LLB, member of Porter, Purtell, Purcell, Wilmot & Burroughs, SC and President-elect, American Society of Hospital Attorneys, "Legal Responsibilities of the Physician in the Treatment of Acute Injury;" John S. Hirschboeck, MD,* Coordinator, Wisconsin Regional Medical Program, Inc., "An Emergency Service Plan for the State of Wisconsin;" Joseph C. Darin, MD,* Professor of Surgery, Medical College of Wisconsin, "Plans for Improved Care of the Trauma Victim in Milwaukee and Wisconsin Areas;" Charles H. Rule, Chief, Fire Department, Greenfield, and President, Metropolitan Milwaukee Fire Chief Association, "Emergency Medical Service—The Viewpoint of a Fire Chief;" and Leonard W. Worman, MD,* Professor of Surgery, Medical College of Wisconsin, "American Trauma Society."

Newly elected officers are: president, Wilson Weisel, MD,* Milwaukee; president-elect, Kenneth E. Lemmer, MD,* Madison; vice-president, Walter P. Blount, MD,* Milwaukee; secretary–treasurer, Kendall E. Sauter, MD,* Wauwatosa; councilor, Wayne J. Boulanger, MD,* Milwaukee; immediate past president, P. Richard Sholl, MD,* Janesville.

Wisconsin Dermatological Society Elects

Robert B. Pittelkow, MD* of Milwaukee in October was elected president of the Wisconsin Dermatological Society, succeeding R. R. Baumann, MD* of Monroe. Stephen B. Webster, MD* of La Crosse was elected secretary, succeeding H. V. Moss, MD* of Madison.

NC Wisconsin Orthopedic Society Met

The North Central Wisconsin Orthopedic Society met November 11 in the Library of the Marshfield Clinic. A number of interesting orthopedic cases were discussed. The Spring meeting will be held in April in Wausau.

Midelfort Clinic, Eau Claire, Expands

The Midelfort Clinic in Eau Claire has announced a major expansion program. Construction of a three-floor $300,000 addition to the clinic will be completed by May 1, 1973, reports Glenn Anderson, administrator. It will provide 35 more examination rooms, more office and waiting room space, and result in some remodeling to other areas of the clinic.

Founded in 1927 by Dr. Christian Midelfort,* the clinic opened at its present site in June 1969 and is constructed to accommodate 23 doctors, Mr. Anderson notes, although the staff increased to 27 doctors this summer.

Physician Assistant Education Program Started

Wisconsin's first formal education program for physician assistants has been established under an $83,982 award to the Marshfield Clinic Foundation for Medical Research and Education.

Frederick J. Wenzel, executive director of the Foundation, said the contract, from the Bureau of Health Manpower, Washington, D. C., is the Foundation's first funded program in the area of health education.

The two-year physician assistant program, under the direction of Francis N. Lohrenz, MD* and Robert Payne, RN, began recently with ten students from Wisconsin and Iowa. The new venture, under the sponsorship of the Foundation, is a joint effort involving the Marshfield Clinic, St. Joseph's Hospital, Marshfield; the University of Wisconsin, Marshfield; and area VTAE District 14.

An informal education program has been in operation in Marshfield for the past five years. Primarily, it has involved on-the-job training. The new program, with a full curriculum and college transfer credits, will be submitted for approval to the Council on Medical Education of the American Medical Association.

In commenting on the program, David J. Ottensmeyer, MD,* Marshfield Clinic president, noted that the Marshfield program will devote itself to training primary care physician assistants who will be involved with the patients of their employers in all settings of medical care: the office, ambulatory clinic, hospital, patient's homes, extended care facility or nursing home. The work as defined, however, will always remain under the supervision of the physician who retains responsibility for patient care, he emphasized.

According to Mr. Payne, more than 3,000 applications for the Marshfield program have been received. Inquiries from 175 physicians also have been received seeking graduates from the program. He further noted that there are approximately 160 other such programs throughout the country.

Workshop on Hearing Measurement

The State Medical Society's Division on Ear, Nose, and Throat cooperated with the University of Wisconsin Center for Health Sciences Division of Otolaryngology in presenting a Workshop on Hearing Measurement and for the Training of Industrial Audiometric Technicians, October 26–27, at the Wisconsin Center in Madison.

Correction to Otolaryngological Society Officers

The November issue of *WMJ* incorrectly reported that Roger Lehman, MD* of Wood was the newly elected president of the Wisconsin Otolaryngological Society. The new president is James H. Brandenburg, MD* of Madison who succeeded Doctor Lehman as president in September. John M. Mills, MD* of Green Bay is the president-elect. Doctor Lehman is currently chairman of the State Medical Society's Section on Otolaryngology. Timothy J. Donovon, MD* of Madison currently serves as secretary to both the Wisconsin Otolaryngological Society and the Section on Otolaryngology.

MCW Receives Grant for Parkinson's Disease Research

Researchers at the Medical College of Wisconsin, Milwaukee, have received a $40,000 grant from the National Science Foundation to quantitatively measure tremor, rigidity, and bradykinesia, major symptoms of Parkinson's disease. The grant was effective December 1 and will expire on May 31, 1975.

Sang Bock Lee, MD

. . . Eau Claire, recently joined the medical practice of Eldon F. Hill, MD,* S.E. in the practice of obstetrics and gynecology. He is a graduate of Chunnam University Medical School, South Korea, and served four years as a surgeon in the Korean Army. He completed a one-year internship at Cleveland, Ohio, and a three-year residency at St. Thomas Hospital, Akron, Ohio, before moving to Eau Claire.

Harold P. Rusch, MD

. . . Madison, was elected president of the American Cancer Society, Wisconsin Division, Inc., at its annual meeting October 14 at the Pioneer Inn in Oshkosh. Doctor Rusch is director of the Clinical Cancer Research Center, University of Wisconsin–Madison. Doctor Rush also was recipient of an American Cancer Society National Award October 24 during its annual meeting in New York City.

Frederick M. Bannister, MD*

. . . Chetek, recently was named a diplomate of the American Board of Family Practice as a result of passing a certification examination administered under the aegis of the ABFP.

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John K. Scott, MD*

. . . Madison, was elected to the Board of Directors of the American Cancer Society October 24 at its annual meeting of the House of Delegates in New York City. Doctor Scott, associate clinical professor of surgery and otolaryngology at the University of Wisconsin Medical School, was named delegate director for a two-year term. He has previously served as a delegate for several years. Doctor Scott was president of the Society's Wisconsin Division in 1968–69 and has been a member of its Board since 1964. Doctor Scott also serves as chairman of the State Medical Society's Committee on Cancer. He is a member of the American College of Surgeons, American Society of Head and Neck Surgeons, and a Diplomate of the American Board of Ophthalmology and Otolaryngology.

Garfield W. Brown, MD

. . . Ashland, recently opened his office for the practice of general surgery in Ashland. He graduated from the University of Minnesota School of Medicine in 1964 and served his internship and residency at La Crosse and St. Paul Ramsey Hospital. Doctor Brown served in the United States Army from 1965–67 with the American Embassy, Bangkok, Thailand, and as battalion surgeon at Fifth Army Headquarters, Chicago.

Donald P. Schlueter, MD*

. . . associate professor of medicine, Medical College of Wisconsin (MCW), on November 8 addressed the International Conference of Pulmonary Reactions to Organic Materials in New York City. He discussed two case studies of respiratory illness among workers in the paper manufacturing industry. Doctor Schlueter and his colleagues at MCW have found that "respiratory disease resulting from prolonged exposure to logs contaminated with Alternaria, an organic dust, may be due to a hypersensitivity reaction."

Robert E. Condon, MD

. . . has been appointed professor in the Department of Surgery, Medical College of Wisconsin, Milwaukee, and Chief of Surgical Services at the VA Center, Wood. Doctor Condon had been professor and head of the Department of Surgery, University of Iowa, College of Medicine. He received his MD degree in 1957 from the University of Rochester. After interning at King County Hospital, Seattle, he took residency training in surgery at the University of Washington. He was named senior fellow in surgery in 1960 and instructor in surgery in 1962. From 1961 to 1963 he was a postdoctoral fellow of the National Heart Institute. In 1963 Doctor Condon received a Guggenheim Fellowship for the study of human liver diseases at the Royal Free Hospital, London. He was appointed assistant professor of surgery at Baylor College of Medicine, Houston, in 1965. An associate editor of *Review of Surgery* and of the *Journal of Surgical Oncology,* he also is co-author of two books: "Abdominal Pain: A Guide to Rapid Diagnosis" and the "Manual of Surgical Therapeutics."

David T. Uehling, MD*

. . . of the Division of Urology, University Hospitals, Madison, presented a paper before the American Academy of Pediatrics on October 14 in New York City entitled "Immunoglobulin Excretion in Children with Cystitis Cystica." Doctor Uehling also became a Fellow of the Section of Urology of the American Academy of Pediatrics.

Norman O. Becker, MD*

. . . Fond du Lac, was elected to the Board of Governors of the American College of Surgeons at its recent annual Clinical Congress in San Francisco. Reelected to the Board was Jerome J. DeCosse, MD,* Milwaukee. The College has 189 Governors. Robert C. Hickey, MD, Houston, Tex., former chairman of the Department of Surgery at University Hospitals, Madison, was reelected vice-chairman of the Board.

James E. Conley, MD*

. . . Milwaukee, was elected chairman of the board of directors of the Milwaukee Division of the American Cancer Society at its recent annual meeting in Milwaukee.

James L. Weygandt, MD*

. . . Sheboygan Falls physician who has been prominent in highway safety work, recently was elected president of the American Association for Automotive Medicine. Doctor Weygandt, vice-chairman of Governor Patrick Lucey's advisory council on highway safety, was elected at the Association's recent annual conference in Chapel Hill, N.C. He is chairman of the State Medical Society's Commission on Safe Transportation and also is a member of the National Safety Council's Committee on Alcohol and Drugs, and the American College of Sports Medicine.

John F. Walsh, MD*

. . . and his wife, of Port Washington, recently toured Europe with a group of doctors studying medical practices there and at one point they visited a hospital in Moscow where, much to their surprise, they met another Port Washington doctor, Arnold H. Barr, MD,* who also was visiting the hospital as a member of another touring group of doctors on the same mission.

Kenneth L. Strebe, MD*
Robert D. Heinen, MD*

. . . are principals in the Family Medical Center located next to Community Memorial Hospital in Oconto Falls. The hospital and clinic recently had an open house to formally dedicate the new health care facilities. The Family Medical Center operates in a clinic owned by the hospital and leased to the Center. The two doctors recently welcomed H. Keith Stinson, MD,* an orthopedic surgeon, to the clinic staff.

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PHYSICIAN BRIEFS . . .

H. Gladys Spear, MD*

. . . has informed the State Medical Society that she has *not* retired from active medical practice as some sources have reported. She continues her private practice in psychiatry at 1610 North Prospect Avenue in Milwaukee. She also is on the courtesy staff of Milwaukee Psychiatric Hospital and is consultant to St. John's Home for the Aged. Doctor Spear came to Milwaukee in 1945 for a residency at the Milwaukee Sanitarium. Except for a brief period when she spent 15 months in residency at the Chicago Institute for Psychoanalysis, Doctor Spear has remained in Milwaukee in private practice and consultative positions. In 1949 she became psychiatric director of Milwaukee Psychiatric Services. According to the BULLETIN of the Wisconsin Psychiatric Association she is "one of the best known and best loved members" of the WPA.

Stanley F. Wyner, MD*

. . . Madison, recently was admitted to the fellowship of the Royal College of Physicians of Canada. He is consultant radiologist to the Odana Medical Center, Madison, and Vernon Memorial Hospital, Viroqua.

Ernest O. Henschel, MD*

. . . professor and chairman of the department of anesthesiology at the Medical College of Wisconsin, Milwaukee, was the organizer of the Second Midwest Seminar for Recovery Room and Special Care Area Nurses which was held in October in Milwaukee. Over 300 nurses registered for the seminar, some from as far away as Alaska and California. Doctor Henschel also is director of the department of anesthesiology and operating room and recovery room services at Milwaukee County General Hospital and chief of anesthesiology and inhalation therapy services at the VA hospital in Wood. □

NEWS HIGHLIGHTS . . .

Children's Heart Center Set Up to Serve State

A unique medical facility to help prevent, diagnose, and treat the heart and circulatory problems of infants and children throughout Wisconsin was announced in November at a news conference by H. David Friedberg, MD,* Milwaukee cardiologist and president-elect of the Wisconsin Heart Association. Doctor Friedberg said the Pediatric Cardiovascular Center of Wisconsin is the most comprehensive and only privately-financed program of its type in the country. The Center is based at the Milwaukee Children's Hospital.

"The importance of this new project is its total approach," Doctor Friedberg explained. "It will combine all the most sophisticated facilities and a complete round-the-clock professional staff with the necessary communication, transportation and auxiliary services."

Also present at the conference were five members of the Center's professional medical team, all child specialists. They include two cardiologists, William J. Gallen, MD* and David Z. Friedberg, MD; a cardiovascular surgeon, S. Bert Litwin, MD; a nurse educator, Janis Campbell, RN, and a child psychiatrist, Lucille Glicklich, MD.* The two Friedbergs are not related.

Discussing the need for a program of this type, Cardiologist David Z. Friedberg pointed out that each year more than 600 children are born in Wisconsin with congenital heart disease; hundreds more suffer from acquired or genetic heart disease.

"These are the young patients that this facility is designed to help," the cardiologist explained. "With early detection and proper treatment, many problems thought to be 'hopeless experiments of nature' can be repaired so these children can live normal lives."

This subject will be further reported by Doctor Friedberg in an article to be published in an early issue of the *Wisconsin Medical Journal.*

Among the unique facilities included at the Center are:

★ A new twenty-one bed intensive care unit, the only one in the state designed only for children.

★ A physicians' and nurses' "hot line" telephone system which makes emergency consultation available 24 hours a day.

★ A specially equipped ambulance which contains an infant transportation isolette and other necessary equipment.

★ All the latest, most sophisticated cardiovascular equipment, miniaturized for the young patient.

"A number of services of this center will also be 'firsts'," David Z. Friedberg continued. "Of primary importance will be continuing education efforts for physicians and nurses. Working with Wisconsin Heart, we'll be holding lectures on a regular basis throughout Wisconsin, as well as an annual statewide seminar on pediatric cardiology and cardiovascular surgery to improve prevention, early detection and treatment."

He added that community education programs would also be stressed to improve early detection of children's heart problems, particularly rheumatic heart disease.

The program will be co-financed by Milwaukee Children's Hospital, the Medical College of Wisconsin, the Fairchild Cardiac Study Center, and the Wisconsin Heart Association. The former three institutions will provide the facilities, equipment, and personnel; Wisconsin Heart is supplying $9,300 in program support and consultation services. □

OBITUARIES

Cecil R. Gilbertsen, MD, 67, Janesville, died Sept. 5, 1972 in Janesville.

Born on Mar. 10, 1905 in Glenburn, North Dakota, Doctor Gilbertsen graduated from Rush Medical College, Chicago, in 1933 and served his internship at the Illinois Central Hospital in Chicago. He was a Janesville physician for over 38 years and was a past president of the Rock County Medical Society. He was president of the medical staff of Mercy Hospital in 1953 and served in the United States Medical Corps during World War II.

He also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Dorothy; two sons, James, Chicago, and Richard, Durham, N. C.; and a daughter, Mrs. Robert P. Stone, Dayton, Ohio.

Richard F. Inman, MD, 72, Montello physician for 34 years, died Sept. 5, 1972 in Madison.

Born on Aug. 9, 1900 in Chicago, Ill., Doctor Inman graduated from the University of Illinois College of Medicine in 1926 and served his internship at West Side Hospital, Chicago, Ill. Doctor Inman had been chief of staff at Divine Saviour Hospital in Portage and had helped organize the blood bank in the county.

In 1966, he received the city's Distinguished Citizen of the Year award by the Chamber of Commerce for his active part in community affairs.

He was a member of Columbia–Marquette–Adams County Medical Society, State Medical Society of Wisconsin, American Medical Association, and American Academy of Family Physicians.

Surviving are his widow, Lois; a daughter, Mary (Mrs. Philip Marrow), Watertown; and a son, Richard, Annapolis, Md.

Arno R. Langjahr, MD, 77, Milwaukee physician for over 40 years, died Sept. 7, 1972 in Milwaukee.

Born on May 13, 1895 in Plymouth, Wis., Doctor Langjahr graduated from Rush Medical College in 1920 and served his internship at Columbia Hospital in Milwaukee. Doctor Langjahr was a member of the medical staff of Columbia, Deaconess, and St. Joseph's hospitals. He retired from practice in 1962.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Isabel; and three daughters, Mrs. Richard Stout, Cleveland, Ohio, Mrs. Robert Burchinal, Phoenix, Ariz., and Mrs. Carl Lund, Arlington Heights, Ill.

Adolph L. Natenshon, MD, 68, Milwaukee physician for over 36 years, died Sept. 7, 1972 in Milwaukee.

Born on May 28, 1904 in La Crosse, Wis., Doctor Natenshon graduated from Northwestern University Medical School in 1933 and served his internship at Wesley Memorial Hospital, Chicago, and Milwaukee County Hospital. For the last six years he was the physician for the Milwaukee Post Office and also was on the medical staff of Mount Sinai Medical Center.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Tillie; and two sons, Dr. Howard B. of Boston, Mass., and Louis J. of Chicago.

Wallace W. Coon, MD, 86, Walworth, died Sept. 14, 1972 in Walworth.

Born May 16, 1886 in Utica, Wis., Doctor Coon graduated from Hahnemann Medical College, Chicago, Ill., in 1912. He served his internship at Hahnemann Hospital in Chicago and also was an Army physician during World War I. Doctor Coon practiced in Wauconda, Ill., and Gays Mills before locating in Walworth.

In 1962, he was honored by the State Medical Society of Wisconsin with a membership in the "50 Year Club." He also was a member of the Walworth County Medical Society and American Medical Association.

Surviving are his widow, Linda; a daughter, Mrs. Bruce (Beverly) Blazier, Capron, Ill.; three sons, George, Dearborn, Mich., Francis, Madison, and Wallace, Jr., Anaheim, Calif.

Harold F. Beglinger, MD, former Wisconsin physician, died in October, 1972 in Palm Springs, Calif.

Born on Oct. 13, 1896 in Oshkosh, Doctor Beglinger graduated from Rush Medical College, Chicago, Ill., in 1927 and served his internship at St. Anthony's Hospital, Chicago.

He served in the United States Infantry during World War I and was in medical practice in Neenah and Mosinee. He was on the medical staff of Theda Clark Memorial Hospital and moved to California in 1969 when he retired from medical practice.

Doctor Beglinger was a member of the Marathon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Louise, and two children.

Herman C. Koch, MD, 78, Berlin, died Oct. 13, 1972 in Berlin.

Born on Jan. 13, 1894 in Harvard, Ill., Doctor Koch graduated from the University of Illinois College of Medicine in 1916 and served his internship at the Indianapolis City Hospital, Indianapolis, Ind. He served in the United States Medical Corps during World War I. Doctor Koch retired from practice in 1962.

He was a member of the "50 Year Club" of the State Medical Society of Wisconsin. He also was a past president of the Green Lake–Waushara County Medical Society and a member of the American Medical Association.

Surviving are his widow, Iolyn; a daughter, Dr. Betty K. Erwin, Seattle, Wash., and a son, Dr. John C. of Berlin.

Maxwell B. Llewellyn, MD, 58, Janesville pathologist, died Oct. 14, 1972 in Janesville.

Born on Mar. 12, 1914 in Oak Park, Ill., Doctor Llewellyn graduated from the University of Minnesota School of Medicine in 1940 and served his

internship at Milwaukee County General Hospital. He taught at Wayne State University, Detroit, Mich., and served a residency at Henry Ford Hospital in Detroit. In July 1947, he became pathologist and director of Laboratories at Asbury Hospital, Minneapolis, Minn.

He came to Janesville in 1949 and served as pathologist and director of laboratories at Mercy Hospital and later assumed similar positions at Edgerton and Ft. Atkinson hospitals.

When he established the blood bank in 1949 at Mercy Hospital, Janesville, it was the first private accredited blood bank in Wisconsin. In 1966 he also opened a laboratory in Janesville for the private practice of pathology.

He was a fellow of the American College of Pathologists, the American Clinical Society of Pathologists, the Academy of Forensic Pathology, a member of the Pan American Society of Medical Practitioners and was a former president of the Wisconsin Society of Pathologists. He also was a member and past president of the Wisconsin Association of Blood Banks, and a member of the International Academy of Pathologists and Bacteriologists.

He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Gertrude; and three sons, David, Wethersfield, Conn.; John, Boulder, Colo.; and Richard, Janesville.

Edmund A. Scholter, MD, 85, Milwaukee, died Oct. 30, 1972 in Milwaukee.

Born on May 6, 1887 in Detroit, Mich., he graduated from Marquette University School of Medicine in 1917 and did postgraduate work at Harvard University, the University of Vienna, Austria, and the University of Chicago. Doctor Scholter was an anatomy professor at Marquette University from 1921–1929 and was on the medical staff of St. Michael Hospital from 1937 until his retirement in 1967. Doctor Scholter was a veteran of World War I, a member of the Industrial Medical Association, and was president of the American Medical Society in Vienna, Austria, in 1930. He was a captain in the Medical Reserve Corps, 1924–1929.

He also was a "50 Year Club" member of the State Medical Society of Wisconsin and a member of The Medical Society of Milwaukee County and American Medical Association.

Doctor Scholter was surgeon for St. Joseph's Benevolent Society, 1932–1970; panel physician and surgeon for City of Milwaukee, 1936–1972; medical director of Catholic Knights of Wisconsin Insurance Co., 1944–1970, and was a member of the Association of Military Surgeons, 1925, and the Catholic Physicians Guild.

Surviving are his widow, Irene; a daughter, Mrs. Francis Schlax of Northbrook, Ill., and a son, Carl J., of Rapid City, S. D.

George A. Parish, MD, 65, Mayville physician for 35 years, died Nov. 3, 1972 in Beaver Dam.

Born on Apr. 15, 1907 in Marinette County, Doctor Parish graduated from the University of Wisconsin Medical School in 1933 and served his internship at Madison General Hospital. He practiced in Amery for one year before moving to Mayville. He had served as Mayville City Health Officer. He was a former chief of staff of St. Joseph's Hospital (now Hillside) in Beaver Dam and was on the medical staffs of Lutheran Deaconess Hospital (now Lakeside), Beaver Dam, and Waupun Memorial Hospital.

He was medical examiner for 52 insurance companies and The Standard Oil Company of New Jersey.

He was a member of Dodge County Medical Society, State Medical Society of Wisconsin, and American Medical Association. Doctor Parish also was a member of the Wisconsin Anti-Tuberculosis and Respiratory Disease Association and American Heart Association.

Surviving is his widow, Ruth.

Francis F. Rosenbaum, MD, 60, Milwaukee, widely known cardiologist, died Nov. 7, 1972 in Milwaukee.

Born on Apr. 17, 1912 in Kalamazoo, Mich., Doctor Rosenbaum graduated from the University of Michigan Medical School in 1936. He served his internship and residency at University Hospital in Ann Arbor, Mich., and became assistant resident at Peter Bent Brigham Hospital in Boston.

Doctor Rosenbaum taught at the University of Michigan Medical School and in 1946 joined the faculty at the Marquette University School of Medicine (now The Medical College of Wisconsin) as an assistant professor and later became a clinical professor of medicine. He was on the attending or consulting medical staffs of most major hospitals in the Milwaukee area.

Doctor Rosenbaum was one of the founders of the Wisconsin Heart Association and was its president in 1950–1951. Because of his many services to the heart associations, Doctor Rosenbaum was to have received the American Heart Association's "Award of Merit" at its meeting in Dallas, Tex., a week after his death. He had held numerous leadership positions in the Association and was its vice-president in 1967.

He was a fellow in the Council on Clinical Cardiology of the American Heart Association, the American College of Physicians and the American College of Cardiology. He was a member of the Milwaukee Society of Internal Medicine, Milwaukee Academy of Medicine, and American Heart Association. He also was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Bernice; a daughter, Mrs. Henry Eckstein, Whitefish Bay, and a son, James G., at home. □

MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Hospitals and Clinics in Wisconsin are particularly invited to utilize this listing service. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication. For listing of other meetings see the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION. Continuing Education Courses for Physicians *for period Sept. 1, 1972 through Aug. 31, 1973 appeared in* JAMA *(Supplement) Aug. 14, 1972.*

1973 WISCONSIN

Jan. 17: State Medical Society In-Depth Teaching Program, St. Mary's Hospital Medical Center, Madison.

Feb. 1–4: Third Annual Winter Refresher Course for Family Physicians, Medical College of Wisconsin and Wisconsin Academy of Family Physicians and its Milwaukee Chapter, Pfister Hotel, Milwaukee. Info: Mrs. Elaine Gamerdinger, Continuing Education Department, MCW, 561 North 15th St., Milwaukee, Wis. 53233; tel. 414/272–5450, ext. 320.

Feb. 3: Symposium on "Recent Advances in Gastrointestinal Endoscopy," Medical College of Wisconsin's Office of Continuing Education, Wingspread Conference Center, Racine. Info: Joseph E. Geenen, MD, Course Director, Department of Medicine, MCW, 8700 West Wisconsin Ave., Milwaukee.

Feb. 13–15: Tenth Annual Telemark Symposium and Ski-Outing, Indianhead Chapter, Wisconsin Academy of Family Physicians, Mt. Telemark near Cable.

Feb. 15: State Medical Society In-Depth Teaching Program, Madison General Hospital, Madison.

Mar. 18–20: Annual Meeting, Wisconsin Association for Perinatal Care, Pioneer Inn, Oshkosh.

Mar. 25–27: State Medical Society Annual Meeting, Pfister Hotel, Milwaukee.

Mar. 26–27: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

Mar. 27: Spring Meeting, Wisconsin Surgical Society, Milwaukee.

Apr. 11: Family Practice Conference, Neenah.

Apr. 12: Family Practice Conference, Wausau.

Apr. 18: Family Practice Conference, Eau Claire.

Apr. 25–27: Advances in Diagnosis and Management of Infectious Disease, University of Wisconsin, Madison; Director, Calvin M. Kunin, MD, FACP. Info: Registrar, Postgraduate Courses, ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

May 9: Family Practice Conference, Neenah.

May 10: Family Practice Conference, Wausau.

May 16: Family Practice Conference, Eau Claire.

Oct. 27: Fall Meeting, Wisconsin Chapter—American College of Surgeons, Marshfield Clinic, Marshfield (tentative).

1973 NEIGHBORING STATES

Feb. 7–9: Nuclear Medicine Conference, Hackley Hospital and the Central Chapter of the Society of Nuclear Medicine, Petoskey, Mich. Info: James C. Carlson, MS, Radiological Physics, Hackley Hospital, 1700 Clinton St., Muskegon, Mich.

Feb. 22–24: 16th Congress on Administration, American College of Hospital Administrators, The Palmer House, Chicago, Ill.

Mar. 5–10: Continuing education course in Laryngology and Bronchoesophagology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, Chicago. 1855 West Taylor St., Chicago, Ill. 60612.

Mar. 26–29: Continuing education course in Neurotology, Department of Otolaryngology of the Abraham Lincoln School of Medicine and the University of Illinois Hospital Eye and Ear Infirmary, University of Illinois at the Medical Center, 1855 West Taylor St., Chicago, Ill. 60612.

May 5: 18th Annual All-Day Scientific Session—Michigan Society of Anesthesiologists, Sheraton–Cadillac Hotel, Detroit, Mich.

Oct. 7–11: Annual Meeting, Michigan State Medical Society, Detroit, Mich.

Oct. 15–19: Annual Clinical Congress, American College of Surgeons, Chicago.

1973 OTHERS

Feb. 7–9: Twenty-Fifth Annual Meeting American Academy of Occupational Medicine, Royal Orleans Hotel, New Orleans, La. Info: James M. MacMillan, MD, Medical Director, Reynolds Metals Co., 6601 W. Broad St., Richmond, Va. 23218.

Feb. 15–16: 37th Annual Meeting International Medical Assembly of Southwest Texas. Gunter Hotel, San Antonio, Texas. Info: Mr. S. E. Cockrell, Jr., Executive Director, 202 West French Place, San Antonio, Tex. 78212.

Feb. 20–23: 25th Annual Meeting American Academy of Forensic Sciences. Las Vegas–Hilton, Las Vegas, Nev. Info: Dr. James T. Weston, 44 Medical Drive, Salt Lake City, Utah 84113.

Feb. 21–24: Surgery of the Hand, University of Colorado School of Medicine, Office of Continuing Medical Education, 4200 East Ninth Ave., Denver, Colo. 80220.

Feb. 25–Mar. 3: *Continuing Education for Excellence in Medicine and Surgery.* Annual Meeting of the American Society of Contemporary Medicine and Surgery. Fountainbleau Hotel, Miami Beach, Fla. Info: Miss Virginia Kendall, 30 N. Michigan Ave., Rm. 1629, Chicago, Ill. 60602.

Mar. 10–11: Provocative Allergy Course, Admiral Semmes Hotel, P.O. Box 1209, Mobile, Ala. Info: Joseph B. Miller, MD, 3 Office Park, Suite 110, Mobile, Ala. 36609.

Mar. 15–16: 22nd Annual Postgraduate Course in Pediatrics of The University of Texas Medical Branch, Galveston, Tex. Info: Lillian H. Lockhart, MD, Chairman, Pediatric Postgraduate Committee, The U of Tex Medical Branch, Galveston, Tex. 77550.

Mar. 29–31: First National Conference on Urologic Cancer, American Cancer Society, Shoreham Hotel, Washington, D. C. Info: Sidney L. Arje, MD, ACS, 219 East 42nd Street, New York, N.Y. 10017.

Apr. 1–4: Spring Meeting, American College of Surgeons, Hilton and Americana Hotels, New York.

May 20–26: American Gastroenterological Association postgraduate course, *Cirrhosis and Portal Hypertension* as part of Digestive Disease Week. Americana Hotel, New York. Info: Mrs. Micki Thomas, Charles B. Slack, Inc., 6900 Grove Road, Thorofare, N. J. 08086.

May 29–31: Postgraduate seminar *Master Interpretation of Clinical Electrophysiology* sponsored by University of Miami School of Medicine and Council on Clinical Cardiology of the American Heart Association. Contemporary Hotel at Disney World, Lake Buena Vista, Fla. Info: Dr. Louis Lemberg, University of Miami School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Sept. 27–29: American Cancer Society's Second National Conference on Cancer of the Colon and Rectum, Americana Hotel, Bal Harbour, Fla. (Accredited by AMA Council on Medical Education.) Info: Sidney L. Arje, MD, Second Colon and Rectum Conference, c/o American Cancer Society, 219 East 42nd Street, New York, N.Y. 10017.

Oct. 20–21: Written certification examination for American Board of Family Practice. Info: Nicholas J. Pisacano, MD, Secretary, ABFP, Inc., U. of Ky. Medical Center, Annex #2, Room 229, Lexington, Ky. 40506.

1973 AMA

Feb. 10–11: Annual Congress on Medical Education, Palmer House Hotel, Chicago, Ill.

Mar. 29–30: 26th National Conference on Rural Health, AMA Council on Rural Health, Dallas, Tex.

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

MEDICAL MEETINGS . . .

1974 WISCONSIN

Mar. 25–26: Annual Scientific Program, State Medical Society of Wisconsin, Milwaukee.

* * *

The Effects of Multiple Injuries. An In-Depth Teaching Program of the State Medical Society of Wisconsin in cooperation with the University of Wisconsin Medical School, St. Marys Hospital Medical Center, and Madison General Hospital will be held January 17 at St. Marys Hospital Medical Center in Madison.

The day's program will start at 9:30 a.m. with morning workshops, a noon luncheon, and the afternoon lectures. Speakers will be S. Craighead Alexander, MD, Professor and Chairman, Department of Anesthesiology, University of Wisconsin Medical School on "The Anesthesiologist's Concerns," and David A. Horwitz, MD, Assistant Professor of Gynecology–Obstetrics, University of Wisconsin Medical School on "The Obstetrician's Concerns."

Objectives of this lecture series is to explore in depth the systemic effects of multiple and massive injuries. Course is designed for physicians maintaining primary care responsibility for patients.

If physicians have not registered for the entire series of four, the individual program fee is $8 payable to: CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis.

Recent Advances in Gastrointestinal Endoscopy. One-day symposium offered by the Medical College of Wisconsin's Office of Continuing Education, February 3, 1973, from 8 a.m. to 5 p.m. at the Wingspread Conference Center, Racine. Discussion will center on duodenoscopy, peritoneoscopy, colonoscopy and cannulation of pancreatic and biliary ducts.

Guest speakers are Meinhard Classen, MD, from the University of Erlangen, West Germany; Kazuei Ogoshi, MD, from the Niigata Cancer Center, Japan, and Jack Vennes, MD, from the Veterans Administration Hospital, Minneapolis, Minn.

The symposium also is sponsored by the University of Wisconsin Medical School, Madison; St. Luke's and St. Mary's Hospitals in Racine, and co-sponsored by the American Society for Gastrointestinal Endoscopy.

As the course is limited to 60 persons, early registration is suggested.

Registration forms and further information can be had by writing to Joseph E. Geenen, MD, Course Director, Department of Medicine, MCW, 8700 West Wisconsin Avenue or Anne T. Finnegan, Office of Continuing Education, MCW, 561 North 15th St., Milwaukee, Wis. 53233.

Refresher Course for Family Physicians. This third annual winter course is sponsored by the Medical College of Wisconsin (MCW) and co-sponsored by the Wisconsin Academy of Family Physicians and its Milwaukee Chapter. To be held February 1–4, 1973, at the Pfister Hotel and Tower in Milwaukee. The four day course will include review and discussion of medical topics of particular interest to family physicians and a practice exam for doctors intending to take the family practice board examination (see ANNOUNCEMENT section in Yellow Pages).

Dr. Lawrence V. Perlman, assistant professor of medicine at MCW and the course director for the sessions, will be assisted by other members of the MCW faculty in presenting the topics. Evening sessions will feature a "Meet the Professor" format, with cases presented by fellows or residents in the various areas for discussion by the professor with the participants.

The course is approved for 24 hours of prescribed credit by the American Academy of Family Physicians.

Registration is unlimited but will close on December 25. For further information on registration and tuition contact Mrs. Elaine Gamerdinger, Continuing Education Department, Medical College of Wisconsin, 561 North 15th St., Milwaukee, Wis. 53233. Telephone—(414) 272–5450 Ext. 320.

Tenth Annual Telemark Symposium and Ski-Outing will be held Tuesday, Wednesday, and Thursday, Feb. 13–15, 1973, at Telemark Lodge near Cable. Sponsored by Indianhead Chapter, Wisconsin Academy of Family Physicians.

Open to all interested persons. Faculty from Mayo Clinic, Rochester, Minn., again will present a scientific program all three days, which is approved for six hours of prescribed credit.

Reception will be held for all participants on Tuesday evening. All ski equipment can be rented, and there are private and group lessons. Rooms available in a new 200-room ski lodge, and 90 town houses on the hill. Also several motels and lodges in the area.

Physicians attending are asked to make their own room reservations (complete list of accommodations is available by writing: Manager, Mt. Telemark Ski Area, Cable, Wis.)

Registration fee of $10 for scientific program, payable at the door. Further info: Wisconsin Academy of Family Physicians, 2825 N. Mayfair Rd., Milwaukee, Wis. 53222.

Three-day emergency nursing course will be held in Milwaukee early next year for nurses specializing in emergency care, intensive care, and coronary care.

Course will be held at the Pfister Hotel and Tower in Milwaukee Jan 31–Feb 2, 1973. Sponsored by Wisconsin (ACS) Committee on Trauma, Medical College of Wisconsin, and emergency department of Milwaukee County General Hospital.

Physicians and professional nurses will present lectures, panels, and seminars on the role of the nurse in the emergency medical system, cardiopulmonary resuscitation, care of the multiple trauma victim, medical emergencies, the psychiatric patient, care of the cardiac patient, ECG monitoring, triage and management and staffing of the ED.

Further information, contact Joseph C. Darin, MD, chairman, Wisconsin Committee on Trauma, 8700 W Wisconsin Ave, Milwaukee, Wis 53226.

American College of Surgeons announces its first annual four-day Spring Meeting, in New York, Sunday, April 1 through Wednesday, April 4, at the Americana and Hilton hotels.

Eight structured postgraduate courses, some supplemented by plenary sessions and small workshop discussions comprise the program, which is planned to correlate with the Surgical Education and Self-Assessment Program (SESAP) of the College.

Registrants may choose one of the four courses offered the first two days, and a second course from those four offered the second two days. Courses and chairmen for Sunday, April 1, and Monday, April 2, are:

. . . *Cancer,* Dr. Edward J. Beattie, Jr., chairman and SESAP representative; Dr. Loren J. Humphrey, co-chairman.

. . . *Shock,* Dr. Arthur E. Baue, chairman and SESAP representative; Dr. Louis R. M. Del Guercio, co-chairman.

. . . *Gastrointestinal surgery,* Dr. Lloyd M. Nyhus, chairman; Dr. S. Arthur Localio, co-chairman; Dr. William S. Blakemore, SESAP representative.

. . . *Pediatric surgery,* Dr. J. Alex Haller, Jr., chairman and SESAP representative; Dr. Thomas V. Santulli, co-chairman.

(Joseph C. Darin, MD, FACS, Milwaukee, will be the presiding officer during the motion picture session Monday, April 2, from 9 a.m. to 12 noon at the Trianon Ballroom of the Hilton Hotel.)

Courses and chairmen for Tuesday, April 3, and Wednesday, April 4, are:

. . . *Fluids and electrolytes,* Dr. Lloyd D. MacLean, chairman; Dr. William M. Stahl, Jr., co-chairman; Dr. Alan P. Thal, SESAP representative.

. . . *Trauma,* Dr. G. Tom Shires, chairman; Dr. Melvin H. Worth, Jr., co-chairman; Dr. Robert J. Freeark, SESAP representative.

. . . *Peripheral vascular disease,* Dr. Edwin J. Wylie, chairman; Dr. Arthur B. Voorhees, Jr., co-chairman; Dr. Francis E. Rosato, SESAP representative.

. . . *Endocrine surgery,* Dr. Richard H. Egdahl, chairman; Dr. Frank E. Gump, co-chairman; Dr. Marion S. DeWeese, SESAP representative.

Surgical infections, cancer of the salivary glands, acute gastrointestinal hemorrhage, hepatitis and the general surgeon, and hand injuries are among topics scheduled for Monday, April 2. Coronary artery disease, bleeding and coagulation, respiratory insufficiency, granulomatous disease of the intestine, cancer, and hemorrhage and thrombosis in 1973 will be discussed on Tuesday, April 3. Motion pictures, Ciné Clinics and some commercial exhibits will also be viewed by registrants.

FEES: Fellows of the College whose dues are paid to date, members of the ACS candidate group, and surgical residents may register free of charge. Non-Fellows, applicants for Fellowship and Fellows whose 1972 dues have not been paid, pay $50. Non-Fellows in the Federal Services (full-time) pay $30. *Everyone* taking postgraduate courses must pay $35 per course. Registration for the meeting is a prerequisite. □

BOOKSHELF

NEW BOOKS RECEIVED are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

Call the Doctor. By Robert F. L. Polley, MD, FAAP. Parents Handbooks, 1197 112th Avenue N.E., Bellevue, Wash. 98004. 1971. 163 pages. Price: $3.00

General Urology. By Donald R. Smith, MD. Lange Medical Publications, Drawer L, Los Altos, Calif. 94022. 1972. 437 pages. Price: $8.50

Synopsis of Gynecology. Eighth Edition. By Daniel W. Beacham, MD and Woodard D. Beacham, MD. 1972. The C. V. Mosby Co., St. Louis, Mo. 413 pages. Price: $10.90

Bone Tumors. Fourth Edition. By Louis Lichtenstein, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 440 pages. Price: $24.50

Pathology of the Cerebral Blood Vessels. By William E. Stehbens, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 661 pages. Price: $44.50

The Truth About Vitamin E. By Martin Ebon. Bantam Books, 666 Fifth Ave., New York, N. Y. 10019. 1972. 154 pages. Price: $1.25

Medical Pharmacology. Sixth Edition. By Andres Goth, MD. The C. V. Mosby Co., St. Louis, Mo. 1972. 704 pages. Price: $16.50

Textbook of Electrocardiography. By David Littmann, MD. Harper and Row, Publishers, Inc., Medical Department, 2350 Virginia Ave., Hagerstown, Md. 21740. 1972. 533 pages. Price: $22.50

Federal Laws: Health/Environment Manpower. Edited by Dr. John T. Grupenhoff & Dr. Stephen P. Strickland. 1972. Science & Health Communications Group, 1730 Rhode Island Ave., N.W., Washington, D.C. 20036. 392 pages. Price: $12.50

Current Pediatric Diagnosis & Treatment. 2nd Edition. By C. Henry Kempe, MD, Henry K. Silver, MD & Donough O'Brien, MD. Lange Medical Publications, Los Altos, Calif. 1972. 1008 pages. Price: $12.00

Eater's Digest—The Consumer's Factbook of Food Additives: Are They Safe? By Michael F. Jacobson. Doubleday & Company, Inc., Garden City, New York. 1972. 260 pages. Price: $5.95

Malnutrition: Its Causation and Control —Vol. I & II. By John R. K. Robson. Gordon and Breach, Science Publishers, Inc., 440 Park Ave., South, New York, N. Y. 10016. 1972. 613 pages.

Baby's Recipe Book. By Linda McDonald. A. S. Barnes and Co., Inc., Box 421, Cranbury, N. J. 08512. 1972. 271 pages. Price: $8.95

Biopharmaceutics and Drug Interactions. By Donald E. Cadwallader, PhD. Roche Laboratories, Division of Hoffmann-LaRoche, Inc., Nutley, New Jersey 07110. 1971. 140 pages

The Parents' Guide to Drugs. By Matthew Andrews. Doubleday & Co., Inc., Garden City, N.Y. 1972. 186 pages. Price: $2.50

Television and Growing Up: The Impact of Televised Violence. From the Surgeon General's Scientific Advisory Committee on Television and Social Behavior. National Institute of Mental Health, 5600 Fishers Lane, Rockville, Md. 1972. 169 pages.

Medical Specialty Terminology. By Clara Gene Young, and Joseph J. Likos, MD. 1972. The C. V. Mosby Co., St. Louis, Mo. 283 pages. Price: $15.75

U.S. Health Care: What's Wrong and What's Right. By Stephen P. Strickland. Potomac Associates, Inc., 1707 L Street, NW, Washington, D.C. 20036. 1972. 127 pages.

BOOK REVIEWS

Ski at Any Age.

By Merritt H. Stiles, MD and Robert D. O'Malley, MD. Award House, Box 562, Farmingdale, New York 11735. 1971. 115 pages. Price: $5.95.

This delightful small book was produced by two physicians from opposite sides of the United States whose mutual interest in skiing and physical fitness brought them together. Doctor O'Malley is a New Englander with a long history of interests in outdoors' activity, including hiking the length of the Appalachian Trail, while Doctor Stiles, from the state of Washington, had been a tennis and squash fan and did not take up skiing until he was 55, largely because he wanted to keep himself physically fit in an outdoors' activity.

They discuss briefly the nature of conditioning for physical fitness, the reasons it is important for persons of all ages, especially those of middle age or older, and how regular skiing may contribute to the development of physical fitness. The basis for safety in skiing and practical safety tips are well brought out. Edward Scott has contributed a chapter on equipment for the over 40 skier, John Day, one on ski touring, sometimes called cross-country skiing, and Marian Stein, one on the woman skier.

Two of the most interesting chapters concern the programs and favorite runs of the two principal authors and accounts of veteran skiers, some of whom are well known already. The book concludes with an appeal by the authors not to wait too long to enjoy the many pleasures of skiing.—ALLAN J. RYAN, MD

Respiratory Physiology

By N. Balfour Slonim, MD and Lyle H. Hamilton, PhD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 229 pages. Price: $10.75.

This book is excellent for its stated purpose. As is stated in the preface of the book, the authors' major objective was to present clearly and concisely the physiology of respiration stretching the fundamental principles and some applications of basic science to the clinical practice of medicine. It is obvious that these authors know about respiratory physiology and they have attempted to make a concise monograph so that the essential facts of respiratory physiology are available. This they have done.

The book is nicely illustrated with mostly their own illustrations which are easy to understand. Respiratory equations are held to a minimum which makes this a better reference book for doctors not familiar with the subject, for nurse and physician assistants.

I think that this book is certainly a worthwhile addition to the Medical Library of the University of Wisconsin.—KARL L. SIEBECKER, MD

Understanding Laboratory Medicine

By Camillo V. Bologna, MD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 259 pages. Price: $9.80.

Understanding Laboratory Medicine by Camillo V. Bologna, MD, is a textbook of physiology written for medical technology and nursing students, rather than being a technical reference book. The style and language of the volume would also make it valuable for the training of paramedical personnel. Thus the book does not attempt to cover all phases of laboratory medicine, but it emphasizes internal metabolism and basic biochemical physiology. Topics included in depth are water and electrolyte metabolism and their relationship to respiration and renal function. In the section on germ layers and tissue organization, the skeleton, muscles, and connective tissue are emphasized, with clear explanations offered regarding the important laboratory procedures related to each system. The circulatory system, hormones, and enzymes are discussed in greater detail than some of the other topics. The book contains a glossary of important terms which should further serve to make this a valuable reference for students in the paramedical sciences. —S. L. INHORN, MD

Review of Physiological Chemistry

By Harold A. Harper. Lange Medical Publications, Los Altos, California. 1971. 529 pages. Price: $8.00.

This book is a good outline of basic biochemistry that could be used by a student for an "over view" of the field or for review purposes along with a more detailed text or notes. It would appear to be well done with accurate illustrations. The editor has done a careful job of making this volume a "concise source of information" for the field, but this should not be considered a definitive text.—G. H. BURNETT, MD, PhD

CONTRIBUTIONS—CES FOUNDATION

October 1972

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1972:

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George R. Andrews, MD	Contribution

BOOKSHELF . . .

Review of Medical Physiology

By William F. Ganong. Published by Lange Medical Publications, Los Altos, California. 1971. 573 pages. Price: $8.50.

This is the fifth edition of a well known review text that is at present being published in five languages with three additional translations underway. As a student in physiology, a reference of this nature was always a welcome companion as opposed to the weighty classical tomes of human physiology.

The division of subject material is well done with emphasis on brevity. One can refresh one's memory of a number of usually forgotten details of hormonal structure, molecular weights or amino acid sequences by a number of brief episodes of light reading. Unfortunately, with the rapid growth of information emerging from the research front, texts of this nature will ultimately have to be divided into different sub-disciplines of physiology. This is most obvious when one reads the chapters on endocrine related topics as well as those on neurophysiology.

A counter argument to this thought is found in the author's manner of integration of the interdependent systems functional within the body. This I believe is the real forte of this book. Apart from the internal contents of the book it is felt that a less unobstrusive cover would be a positive factor which, if coupled to the low price, would make this book an attractive investment.—IAN H. CARLSON, PHD

Physiology of Reproduction

By William D. Odell, MD and Dean L. Moyer, MD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 152 pages. Price: $12.00.

In the Preface the authors state that their goal in writing this book was to provide information concerning the current concepts of basic reproductive processes in the human. To this end they have succeeded in providing in a succinct manner the recent information on human reproductive physiology. They have not extensively included animal data. Data from other species are included, however, at appropriate points or when human data are limited or lacking. The book is extremely well written and the illustrations are presented clearly. At the end of each chapter a reference list or a list of additional readings is included. In view of the stated goals of the authors, these are very helpful. It should be clear that this is not a textbook nor is it intended to be. Rather it is a presentation of fundamental concepts which will enable the reader to have a sound foundation upon which further study can be built.—RICHARD C. WOLF, PHD

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The views expressed in the articles on legal medicine are those of Society attorneys, or other authors, and do not necessarily represent Society policy; and in some cases represent areas in which no policy exists.

—Statement authorized by House of Delegates, Oct. 22, 1966

The "Blue Book"

SINCE 1924 the Wisconsin Medical Journal has published each January a "Blue Book" edition containing a variety of articles relating to medicolegal, socio-economic matters of direct concern to the physician in his relationship to patients, hospitals, governmental agencies, and others on the "health team." It is unique among medical journals of the United States.

In addition to Society membership, it is distributed gratis to senior and junior medical students of the two Wisconsin medical schools, and is available to others. It is particularly helpful to those who wish to become licensed physicians in Wisconsin.

The "Blue Book" is a useful reference book throughout the year. Physicians are urged to keep the Journal handy at all times.

Save Your "Blue Book" Issue For Future Reference

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL—AMA

The Principles of Medical Ethics of the American Medical Association were condensed in 1957 to a preamble and ten sections. This preamble appears in this issue at page 41. Opinions of the Judicial Council interpreting the Principles are set forth in a booklet entitled, "Judicial Council Opinions and Reports: 1969." The booklet includes the jurisdiction and rules of the Judicial Council. Actions of the AMA House of Delegates relating to the Principles also are reproduced. This guide to good conduct is available upon request to the AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

Medical, dental, and hospital associations form separate corporation to correlate statewide peer review. Their goal: to achieve the highest quality care at the lowest cost for the well-being of patients.

At the State Medical Society's last annual meeting, the Council and House of Delegates authorized the establishment of a separate health care review organization. Since last May implementation has been underway, culminating last month in the signing of incorporation papers for Wisconsin Health Care Review, Inc.

This report on the establishment of the new corporation includes an overview of peer review and a look at the new emphasis on the concept.

Wisconsin Health Care Review, Inc.

A LANDMARK FOR STATE HEALTH PROFESSIONS

By PAUL B. MASON, MD
Sheboygan, Wisconsin

MEDICAL, DENTAL AND HOSPITAL officials signed papers at the State Medical Society of Wisconsin headquarters December 29, 1971, establishing a unique new corporation, Wisconsin Health Care Review, Inc. (WHCRI).

It is designed to act as a monitor of relationships among patients, health care providers, and the groups which pay most of the bills, such as insurance companies and government agencies.

Those who signed WHCRI incorporation papers were: George A. Behnke, MD, Kaukauna, president of the State Medical Society of Wisconsin; Coleman Gertler, DDS, Glendale, president of the Wisconsin State Dental Society; and Dean K. Roe, Wauwatosa, president-elect of the Wisconsin Hospital Association.

WHCRI is a unique application of peer review. It is believed to be the first review organization in the country to include more than one profession—at least on a partnership basis.

The WHCRI board of directors includes four physicians, two dentists, and two hospital administrators. There also will be public representation on the board.

Until the organization becomes operational, the groups who participated in the incorporation will be asked to subsidize it. These groups—the state medical and dental societies and the hospital association—will also be asked to contribute personnel to launch the corporation. It is expected that, with time, WHCRI will have its own staff.

It is not intended that WHCRI replace any of the groups already doing peer review within individual institutions or professional associations. In fact, it is designed to encourage the maintenance of strong working peer review groups within the component organizations.

The role of WHCRI will be primarily leadership and coordination. WHCRI will seek guidelines from each of the component groups and then be principally concerned with seeing that the guidelines are being followed. WHCRI can thus assure the public at large that a well organized, effective program is in operation.

As Dr. Behnke noted at the WHCRI incorporation, "peer review is not a new concept or a new venture." In fact, the establishment of the State Medical Society and the State Dental So-

ciety in the mid-nineteenth century was in effect a type of peer review. The dental and medical societies were formed to set standards for themselves and the practice of their professions at a time when there was no governmental licensure of health care professionals. Their chief concern was elevation of the quality of care through education. In today's climate of sophisticated medical knowledge, peer review serves a very similar function.

This activity is also encouraged by the Wisconsin Hospital Association in the form of in-hospital review programs. That association has participated in such activities as formalized data development so that meaningful statistics are compiled for comparative analyses of hospital usage and quality evaluation.

Peer review has, for many years, been the reason for medical staff committees in hospitals on credentials, therapeutics, utilization, and tissue review. Physicians regularly utilize consultants to verify findings, to solve diagnostic dilemmas, or to provide therapy otherwise not available for patients. This, too, is a form of peer review.

"peer review is not a new concept or a new venture . . . To let the public as well as special interest groups know just what is being done on their behalf, peer review must have greater visibility. This visibility is one of the aims of WHCRI."

Why, if peer review is a time-honored concept, has it been so frequently in the news during the last few years? Why the establishment of a new peer review instrument, WHCRI?

As health care becomes ever more costly and a matter of greater public concern, peer review is increasingly being seen as a way to maintain quality care and make the best use of health facilities and personnel, thereby containing costs.

Dwight Wilbur, MD, former American Medical Association president, referred to this situation in his inaugural address in San Francisco in June of 1968:

"Basically, public opinion is the most powerful determinant and the ultimate force that in the long run will determine the social, economic, and political course of this country, and it will decisively determine the future patterns of health care."

Only if public opinion permits, can professionals continue to deliver health care within the standards they themselves set. Recent publicity indicating the "need" for utilization and peer review programs gives practically no recognition to the long established activities of medicine, dentistry, and the hospitals to assure high standards of patient care nor to the similar efforts of other disciplines. To let the public as well as special interest groups know just what is being done on their behalf, peer review must have greater visibility.

This visibility is one of the aims of WHCRI. It can seek to meet the public's needs and interest, and do so without regard to any particular pending piece of legislation.

Some proposals recently made by congressional committees and governmental personnel at several levels have been characterized by Wisconsin Congressman John Byrnes as imposing "oppressive bureaucratic methods" to safeguard against both over or under utilization. The alleged aim of these proposals is to assure reasonable costs of health care.

As Congressman Byrnes told a delegation of Wisconsin physicians recently, the existence of an operating health care review organization which has demonstrated its capability is likely to have a significant influence on what will be accepted by government as the operating agency in Wisconsin.

Gerald Dorman, MD, president of the American Medical Association in 1969–70, is quoted in a speech to the American Hospital Association as saying: "The health professions can no longer tolerate any institution designed to provide health that ignores economies and efficiency; further, that it is a physician responsibility to accept responsibility for the care of every other physician's patient."

The "Foundation" Concept

Throughout the country an approach to health care review, which has caught on with both professionals and government alike, has been the "foundation" concept. This creature of the privately practicing profession has become a popular means to effect review as a product of the state and county medical society. It offers more visibility to responsible medical leadership than any socioeconomic and quality control development in a generation.

The term "foundation", however, means many different things to different people depending upon the backgrounds, locations, and exposures of those who use it. In some cases it is a tax-exempt corporation with a primary purpose of raising funds to provide scholarships and loans

Signing Wisconsin Health Care Review, Inc., incorporation papers are (left to right): Coleman Gertler, DDS, Glendale, president of the Wisconsin State Dental Society; George A. Behnke, MD, Kaukauna, president of the State Medical Society of Wisconsin; and Dean K. Roe, Wauwatosa, president-elect of the Wisconsin Hospital Association.

to students who wish to pursue a health profession, such as medicine, dentistry, pharmacy, and nursing. Others, as the following text will reveal, cover a wide range of activities; but most of them which are established by medical societies give evidence of physician leadership in efforts to assure effective use of health care resources and funds—and through peer review have the capacity to maintain high standards of health care while at the same time conserving the limited personnel, resources, and facilities.

The typical foundation is separate from the medical society, is a tax-exempt and non-profit corporation, and has its own board of directors. It is concerned with the development and delivery of medical services and the reasonable cost of health care, whether publicly or privately financed.

Some foundations establish standards for health care based on patterns, or norms, in the area. Through peer review, they preserve and enhance the quality of care, guarding against both over-utilization or under-utilization of services in and/or out of the hospital.

The foundation concept provides a mechanism through which professionals may adequately deal with public and private organizations that provide financing for health care services.

Donald C. Harrington, MD, a Stockton obstetrician-gynecologist, conceived the idea for the San Joaquin, Cal., Foundation when he found that there are certain things a medical society cannot do for physicians, patients, and financing mechanisms. He found that a medical society cannot make certain contracts or certain commitments. The foundation as a subsidiary corporation, organized for community service and not for profit, also could be the answer to questions about antitrust violations and restraint of trade laws.

Since the first foundation of this character was born in San Joaquin County, California, in 1954, the foundation idea has spread to other parts of the country. In addition to 18 medical society foundations in California, 17 other states now have medical care foundations. Almost as many other state medical associations have them on the drawing boards.

"The typical foundation is separate from the medical society . . . concept provides a mechanism through which professionals may adequately deal with public and private organizations that provide financing for health care services."

WHCRI - Statements of Officers - WHCRI

GEORGE A. BEHNKE, MD—*President of the State Medical Society of Wisconsin*

Peer review is not a new concept or a new venture. What is new about Wisconsin Health Care Review, Inc. is its provision for teaming up the efforts of a number of health care professionals. This approach has the advantage of a combined and coordinated, rather than a fragmented, approach to reviewing and evaluating the many facets of health care. It draws upon the talents and resources of the principal providers of health services to achieve the goal of quality care at the lowest cost.

COLEMAN GERTLER, DDS—*President of the Wisconsin State Dental Society*

As the three largest providers of health care in the state the need for close cooperation between us in the interests of quality health care has become more imperative than ever. This is an historic occasion whereby the review of health care and its methods of reimbursement will develop a new dimension, complementing the established peer review program of the Wisconsin State Dental Society and the other represented organizations.

Dentistry is proud to be a member of this organization that will help maintain quality care at reasonable costs. This will serve to the benefit of the public, health insurers, and providers.

DEAN K. ROE—*President-elect of the Wisconsin Hospital Association*

The Wisconsin Hospital Association, representing virtually all of the community hospitals in the State, is pleased to join with the State Medical Society of Wisconsin and the Wisconsin State Dental Society in forming Wisconsin Health Care Review, Incorporated. While many hospitals have had effective utilization review programs for several years, we feel that Wisconsin Health Care Review, Inc. can be especially helpful for the smaller hospital, extended care and nursing home facilities, as well as other health care providers, in operating a health care review program which incorporates the principle of peer review. Health care providers are being asked to give evidence of objective evaluation of health care and the utilization of services given to patients in caring for their health needs. We believe that the Wisconsin Health Care Review program can also be a valuable adjunct to those health care providers that have functioning utilization review programs by offering consultation and assistance in improving their operation.

We believe too that Wisconsin Health Care Review, Inc., by making its reviewing and consulting services available to other than health care providers, such as professional organizations representing providers, the insurance industry, the government, and others, that a real service can be rendered in assuring that there is an objective and realistic review of health care and the utilization of health care services. The program also will be useful in disseminating information to and educating not only the organizations associated with the new corporation and their membership but also the general public as it relates to its objectives and their relationship to the health of the public.

The Wisconsin Hospital Association looks forward to participating fully through its Officers and Trustees, and its entire membership, in the work of Wisconsin Health Care Review, Inc. as it develops its program of service in the area of peer review.

DECEMBER 29, 1971

The American Medical Association estimates that by mid-1972 as many as 40 to 45 state medical associations shall have established separate peer review corporations (care foundations) and that more than half will be fully operational. Most of them can be classified under three models: California, Hennepin County (Minnesota), and Missouri.

California Model

The working prototype of the California model is San Joaquin, offering a full range of services. Under medical society sponsorship and control, it conducts care quality review, examines utilization of medical services and facilities, processes and pays claims, and designs coverage for underwriters and groups.

There are 18 foundations serving 32 counties in California. Fourteen of these foundations serve 1,058 groups totaling 620,000 policy owners covered by a dozen cooperating health insurance companies.

The California type foundations deal primarily with employer groups. They cover state employees, and all 18 foundations have contracts to cover county employees. Half of the foundations have contracts to cover city employees. They are strong in school health services programs, ranging from public school districts to universities. All review inpatient services in hospitals, extended care facilities, and nursing homes.

The San Joaquin Foundation administers Medicare, Medi-Cal (Medicaid), CHAMPUS, and the services groups under commercial insurance and the Blue plans. The 18 foundations process, review, and pay about 70,000 claims per month for commercial insurance and Blue plan coverage and about 370,000 per month for public care programs, a total of 440,000 claims per month. In the San Joaquin example, 98 percent of physicians in private practice are participating members.

Payments to California foundations for their services are made by insurance companies and prepayment plans on a premium-percent formula. Most charge 4 to 5 percent of the first $50,000 in premiums for a group and 2.5 to 3.5 percent above the base amount on premiums in excess of $50,000.

Hennepin County Model

The Hennepin County model differs in operational aspects from the California model, but has the same purposes and goals. The differences are in three areas.

First, the Foundation for Health Care Evaluation of Hennepin County does not make minimum standards of coverage a prerequisite for its contracts. The foundation says it chose this course "to avoid the difficulties encountered by other foundations which have designed insurance plans that are more comprehensive than the public or industry is willing to pay for."

Second, the Hennepin Foundation does not process claims for third parties, believing that the insurance companies are best qualified by experience, facilities, and personnel to undertake this task.

Third, peer review function is performed under foundation guidelines by insurance carriers for most claims with only problem cases going into the foundation's peer review committee. The guidelines contain parameters of acceptable fees and medical procedures (from the Michigan Hospital Utilization Review Manual) and are to be used to screen out for more intensive professional review those claims not meeting the criteria.

The Missouri model is essentially a peer review organization. Five district review panels serve the Missouri foundation, each consisting of seven members. Five are MDs representing surgery, family practice, obstetrics and gynecology, and one other specialty optional to the region served. Two members are osteopaths. Utilization guides applied by the district panels are those of the Hennepin Foundation or the Michigan manual.

Missouri Foundation

The Missouri foundation is jointly sponsored by the medical and osteopathic associations. The two statewide professional organizations pay the costs of foundation operations, since no decision has been made on a formula to charge carriers for foundation services.

The Missouri foundation's principal concern is monitoring services provided under Medicare and Medicaid. The foundation does not sponsor insurance or Blue plan coverage, sets no minimum coverage standards for benefit services, and makes no determination as to fees.

To avoid confusion and to minimize the areas of misunderstanding the Wisconsin approach differs from that of the foundations in other areas. At least initially, its only concern is peer review. Its inclusion of more than one discipline is unique, but a logical step in light of the foundation's evolution over the past 17 years.

Dr. Harrington, the California physician who authored the original foundation concept, put it this way at a 1969 conferenee on peer review:

> No discussion of peer review would be complete without reflection on the physicians' responsibility for the review and utilization of physician generated services. This includes drugs, hospitals, extended care facilities, long-term care facilities, etc. To adequately review care being rendered to a patient, all of these services must be the concern of the medical discipline that has ordered this care. If concern for the patient care is to be truly meaningful, peer review by the medical profession must be broadened to accept leadership for utilization review of these other services. This approach quickly develops a cooperating relationship between the peers of other disciplines and the reviewing physician.

"WHCRI shares common threads of similarity with medical care foundations . . . primarily educational"

WHCRI shares common threads of similarity with medical care foundations in its objectives. These are primarily educational, including the:

- promotion of effective use of health care services,
- efficient use of public health care dollars, and
- protection of the reputation of health care professionals by correcting potential misutilization.

However, it also should be clearly understood that:

. . . WHCRI is not something which can or will deny normal practice freedoms and professional prerogatives.

. . . WHCRI does not and cannot affect the privileges conferred by licensure.

. . . WHCRI is not an insurance, prepayment, or government care plan financing mechanism.

. . . WHCRI is not an instrument to punish alleged "wrongdoing."

WHCRI will be able to provide a new service to those who pay health care bills, such as insurance carriers and government agencies. As things stand now, these groups do not have a readily available place to turn when questions about quality of care or use of services arise—especially when more than one health profession is involved. Wisconsin Health Care Review, Inc., is designed to fill this need by having continuously "on tap" a group of professionals who can review such cases.

As requests are made for the use of WHCRI services, contracts will be worked out based on the experience gained by WHCRI and the services desired by those requesting review. A mechanism for reporting results will also have to be developed. It is planned that WHCRI will support itself by charging fees to those who use its services. These will include such groups as employers, health and welfare funds, insurance companies, and government agencies.

Work will be channeled through the individual peer review panels of the professional organizations involved. County or regional committees will need to be set up by each profession or participating association.

An example of the way such a committee could work may be taken from the current functioning of the State Medical Society's Advisory Committee on Utilization Review Programs. The cases it considers are of a fairly complex nature. There often is no clear answer as to the "right or wrong" of the situation.

For example, one recent case involved a physician treating arthritis with a drug not usually considered effective for this disease. The patient's health insurance company felt it should not have to pay for the treatment. The question was referred to the committee, which obtained opinions from medical school and hospital consultants as well as the authors of medical journal articles on the subject.

After all opinions were presented to the committee, it made a recommendation as to whether the health insurance company should be obliged to pay for the treatment.

Another item recently reviewed by the Committee pointed up the problems that can arise when a patient's medical records are not complete. A physician had submitted a claim for treatment which included Vitamin B-12 injections. Available records indicated that the patient had a condition for which this medication was not acceptable therapy and therefore not reimbursable under Medicare Part B.

"WHCRI is not something which can or will deny normal practice freedoms and professional prerogatives . . . does not and cannot affect the privileges conferred by licensure . . . is not an insurance, prepayment, or government care plan financing mechanism . . . is not an instrument to punish alleged 'wrongdoing'"

After the case went to the Committee, the physician submitted further information which showed that the patient also had additional diagnoses. These supplemental diagnoses included conditions for which this form of therapy is appropriate. Accordingly, the claim was then qualified for payment.

On a broader plane the State Medical Society Committee has developed some guidelines regarding length of hospital stays, the frequency of physician visits to hospitalized patients, patients in extended care facilities and nursing homes, the appropriateness of the use of an ambulance in transporting hospitalized patients for specialized treatment not available where they were admitted, billings by more than one physician during a period of concomitant care, and the like.

The establishment of such guidelines is one important function of peer review committees. The Wisconsin State Dental Society has set down guidelines for peer review in dentistry in Wisconsin. These include suggestions for formation and operation of the committees and indicate how third parties can refer cases for review. The Dental Society guidelines include approved definitions of the terms usual, customary, and reasonable as they should be used in disputes related solely to the fee. They also state that requests for review should be the last step when differences between an insurance carrier and a dentist cannot be resolved between themselves or with the use of a dental consultant.

In the future, it is possible that WHCRI also will become active in the area of institutional review of hospital and nursing home stays. This could involve the review of a facility's entire patient population. Even further in the future is the possibility that WHCRI may be involved in evaluating patient cases prior to the time of admission to a hospital or a nursing home. This would necessitate guidelines for admissions and for length of stay.

The key to WHCRI is equitability and advocacy of the patient's well-being, along with—quite candidly—an enlightened self-concern among all interested parties.

WHCRI marks an important step in the health care professions working together in the interest of privately delivered quality care. Its future lies entirely in the hands of the members of the professions involved. Their cooperation is a necessity if this unique and promising new concept is to work.

Medical Peer Review Committee Members

The State Medical Society's Advisory Committee on Utilization Review Programs will act as the medical peer review committee within Wisconsin Health Care Review, Inc.

Members are MDs Paul B. Mason, Sheboygan; William P. Curran, Antigo; Richard W. Edwards, Richland Center; Donald R. Griffith, Eau Claire; Melvin Huth, Baraboo; William D. James, Oconomowoc; Gordon V. Marlow, Madison; John Erbes, Milwaukee; Owen E. Miller, Waukesha; and Arthur J. Jacobsen, Racine.

WHCRI Officers Named at First Board Meeting

The Wisconsin Health Care Review, Inc., board of directors met for the first time December 29 following the signing of incorporation papers. At that time they chose the following officers:

President—Paul B. Mason, MD, Sheboygan, a member of the State Medical Society's Commission on Medical Care Plans and Chairman of the Advisory Committee on Utilization Review Programs; Vice-President—Dean K. Roe, Wauwatosa, President of the Wisconsin Hospital Association and Administrator of Milwaukee Psychiatric Hospital; Secretary-Treasurer—Coleman Gertler, DDS, President of the Wisconsin State Dental Society.

Other directors are: Robert B. Pittelkow, MD, Milwaukee, Past President of The Medical Society of Milwaukee County and a current member of the State Medical Society's Council; John J. Satory, MD, La Crosse, former Chairman of the Wisconsin State Medical Examining Board; Russell P. Sinaiko, MD, Madison, former Chairman of the Dane County Medical Society Insurance Advisory Committee; L. L. Podruch, DDS, Wausau, President-elect, Wisconsin State Dental Society and a member of its Commission on Dental Health; and Kenneth Van Bree, Portage, a member of the Executive Committee of the Wisconsin Hospital Association Board of Directors and Administrator of Divine Savior Hospital and Nursing Home.

Also at the first board meeting, Earl R. Thayer, State Medical Society Secretary, was appointed assistant secretary-treasurer to administer day-to-day WHCRI business. The WHCRI office is at State Medical Society of Wisconsin headquarters, 330 E. Lakeside St., Madison.

Articles of Incorporation

WISCONSIN HEALTH CARE REVIEW, INC.

The undersigned incorporators of a corporation organized under the Wisconsin Nonstock Corporation Law hereby adopt the following Articles of Incorporation:

ARTICLE I
NAME

The name of this corporation is WISCONSIN HEALTH CARE REVIEW, INC.

ARTICLE II
PURPOSES

The corporation is organized and shall be operated exclusively for the following purposes:

1. To develop, promote, coordinate and operate health care review mechanisms which shall incorporate the principle of peer review so as to provide objective evaluation of both health care and the utilization of services encompassing the total health needs of patients, and by such care review mechanisms to help assure the public of the optimum use of health resources and health care expenditures.
2. To make its reviewing and consulting services available to health care providers, professional organizations representing such providers, the insurance industry, the government, and other interested persons, organizations or institutions.
3. To disseminate information to, and educate, its associated organizations, and their members, and the general public, with respect to the foregoing objectives and their significant relationship to public health.
4. To offer to deal with and to delegate to each of the health professions or organizations recognized by the corporation, through such profession's or organization's recognized state society or association, the shared authority and responsibility for conducting peer reviews relating to that profession or organization the claims of whose members the corporation may be asked to review, subject, however, to guidelines for each profession or organization involved in the operation of the corporation, such guidelines to be adopted or established by the board of this corporation; such peer reviews to be further subject to such follow up procedures as the board of this corporation may deem necessary to assure compliance with such guidelines by a review panel. Provided, that no such profession shall be required as a condition of such delegation to deal exclusively with the corporation in matters of peer review; and, provided further that if any profession fails or refuses to accept the described non-exclusive offer to deal with the corporation, then the corporation reserves the option of establishing other methods for accomplishing the peer review which it believes is required with respect to such profession.

ARTICLE III
POWERS

To carry out the purposes expressed in ARTICLE II hereof, this corporation shall have the general powers granted to it by Section 181.04 of the Wisconsin Nonstock Corporation Law, Wisconsin Statutes, 1969.

ARTICLE IV
NON-MEMBERSHIP CORPORATION

This corporation is organized without members.

ARTICLE V
BOARD OF DIRECTORS

The affairs of the corporation shall be managed by a Board of Directors. The number, qualifications, manner of election and term of Directors shall be prescribed by the Bylaws. The initial Board of Directors shall consist of eight (8) persons, whose names and business addresses are:

PAUL B. MASON, MD, 1011 North 8th Street, Sheboygan, Wisconsin 53081

ROBERT B. PITTELKOW, MD, 111 East Wisconsin Avenue, Milwaukee, Wisconsin 53202

JOHN J. SATORY, MD, 1404 Main Street, La Crosse, Wisconsin 54601

RUSSELL P. SINAIKO, MD, 20 South Park Street, Madison, Wisconsin 53715

COLEMAN GERTLER, DDS, 5906 North Port Washington Drive, Glendale, Wisconsin 53217

L. L. PODRUCH, DDS, 110 South 2nd Street, Wausau, Wisconsin 54401

DEAN K. ROE, 1220 Dewey Avenue, Wauwatosa, Wisconsin 53213

KENNETH VAN BREE, 1015 West Pleasant Street, Portage, Wisconsin 53901

ARTICLE VI
DISTRIBUTION OF NET EARNINGS

No part of the net earnings of this corporation shall inure to the benefit of or be distributable to its directors, officers, or other persons; except that the corporation shall be authorized and empowered to pay reasonable compensation for services rendered, and to make payments and distributions in furtherance of the purposes set forth in ARTICLE II herein.

ARTICLE VII
DISSOLUTION

Upon the dissolution of the corporation, the Board shall, after paying or making provision for the payment of all its liabilities, dispose of all its assets consistent with its corporate purposes, or distribute them to such organization or organizations as shall at any time qualify as an exempt organization or organizations under Section 501(c) (3) or (6) of the Internal Revenue Code of 1954, as amended, (or the corresponding provisions of any future United States Internal Revenue Law), all as the Board shall determine.

ARTICLE VIII
PRINCIPAL OFFICE; REGISTERED AGENT

The location of the principal office of the corporation shall be 330 East Lakeside Street (P. O. Box 1109), Madison, Wisconsin 53701, and its initial registered agent shall be Earl R. Thayer, at the same address.

ARTICLE IX
INCORPORATORS

The names and business addresses of the incorporators are:

George A. Behnke, MD, 1015 West Wisconsin Avenue, Kaukauna, Wisconsin 54130

Coleman Gertler, DDS, 5906 North Port Washington Drive, Glendale, Wisconsin 53217

Dean K. Roe, 1220 Dewey Avenue, Wauwatosa, Wisconsin 53213

ARTICLE X
AMENDMENTS

These Articles may be amended or repealed and new Articles may be adopted at any meeting of the Board by a three-fourths (¾) affirmative vote of the directors then in office; provided the text of any such proposed change was included in the notice of the meeting; further provided, at least one director from each organization choosing two or more directors under CHAPTER TWO of the Bylaws shall have voted in favor of such amendment, repeal, or new Articles.

IN WITNESS WHEREOF, the aforesaid incorporators have caused the execution of the foregoing Articles of Incorporation, this 29th day of December, 1971.

(signed) George A. Behnke, MD

(NO CORPORATE SEAL)

(signed) Coleman Gertler, DDS

(signed) Dean K. Roe

STATE OF WISCONSIN
COUNTY OF DANE } ss.

Personally came before me this 29th day of December, 1971, the above named George A. Behnke, Coleman Gertler, and Dean K. Roe, to me known to be the persons who executed the foregoing Articles of Incorporation, and separately acknowledge the same.

Jane M. Ring, Notary Public.
State of Wisconsin.
My Commission expires 10/28/73

These Articles were drafted by
Attorney Robert B. L. Murphy,
Madison, Wisconsin.

BY LAWS of Wisconsin Health Care Review, Inc.

(Adopted December 29, 1971)

CHAPTER ONE
PRINCIPAL OFFICE

The principal office of the corporation shall be located in Madison, Dane County, Wisconsin. The corporation may have such other offices as the business of corporation may require from time to time.

CHAPTER TWO
DIRECTORS

Section 1. *Size of Board; Selection of Directors.* The business and affairs of the corporation shall be managed by a Board of nine (9) Directors. The mode of selection or election of the Directors from each component organization shall be determined by each such organization.

The Board shall be composed of:

(a) Four doctors of medicine chosen by the State Medical Society of Wisconsin;
(b) Two doctors of dental surgery chosen by the Wisconsin State Dental Society;
(c) Two persons chosen by the Wisconsin Hospital Association; and
(d) One person with broad civic interests chosen by the Board of this corporation.

Section 2. *Terms.* At the first annual meeting of the Board, three of the Directors certified by their respective organizations shall be designated by lot for terms of one (1) year; three for terms of two (2) years; and three for terms of three (3) years. Thereafter, all terms shall be for three (3) years; provided an incumbent shall continue in office until his successor has been qualified.

Section 3. *Regular Meetings.* Regular meetings may be held at any time and place, within or without the state, as may be fixed in these Bylaws, or by resolution of the Board.

Section 4. *Special Meetings.* Special meetings of the Board may be called by or at the request of the President, or of a majority of the Directors then serving. The Secretary shall issue the call for a special meeting and fix the time and place thereof.

Section 5. *Annual Meetings.* After consultation with the other officers, the Secretary shall issue the call for the annual meeting and fix the time and place thereof.

Section 6. *Notices.* Notice of any meeting shall be given at least ten (10) days previous thereto by written notice delivered personally or mailed to each Director at his business address, or by telegram. If mailed, such notice shall be deemed to be delivered when deposited

in the United States mail, so addressed and postage prepaid. If notice be given by telegram, such notice shall be deemed to be delivered when the telegram is delivered to the telegraph company. Except as provided in CHAPTER TEN hereof, neither the business to be transacted at, nor the purpose of any regular or special meeting of the Board need be specified in the notice or waiver of notice of such meeting.

SECTION 7. *Quorum.* A majority of the number of Directors serving at a given time shall constitute a quorum for the transaction of business; provided, that if less than a majority of such number of Directors is present at said meeting, a majority of the Directors present may adjourn the meeting from time to time without further notice.

SECTION 8. *Majority Action.* The act of the majority of the Directors present at a meeting at which a quorum is present shall be the act of the Board, except as otherwise required in the Articles of Incorporation, or by Statute. The attendance of a Director at any meeting shall constitute a waiver of notice of such meeting, except where a Director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not in his opinion lawfully called or convened.

SECTION 9. *Waiver of Notice.* Whenever any notice is required to be given to any Director of the corporation under the provisions of the Wisconsin Nonstock Corporation Law, or under provisions of the Articles of Incorporation or Bylaws, a waiver thereof in writing signed by the person or persons entitled to this notice, whether given before or after the time stated therein, shall be equivalent to the giving of such notice.

SECTION 10. *Vacancies.* Any vacancy occurring the Board shall be filled in the manner provided by SECTION 1 of this CHAPTER. A Director chosen to fill a vacancy shall serve for the unexpired term of his predecessor.

CHAPTER THREE

OFFICERS

SECTION 1. *Officers.* The President, the Vice-President, and the Secretary–Treasurer, shall be the general officers of the corporation. Additionally, the Board may designate special officers and determine their functions and terms.

SECTION 2. *Election and Terms of General Officers.* General officers of the corporation shall be elected for one year terms by the Board from its membership, and at its annual meeting, or any adjournment thereof. If the election shall not be held at such meeting, it shall be held as soon thereafter as convenient. New offices may be created and filled at any meeting of the Board. Each general officer shall hold office until his successor shall have been duly elected or qualified, or until his death, resignation, or removal in the manner hereinafter provided. Election or appointment of any officer or agent shall not of itself create contract rights.

SECTION 3. *Removal.* Any officer or agent may be removed by the Board whenever in its judgment the best interests of the corporation will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of the person so removed.

SECTION 4. *Vacancies.* A vacancy in any office caused by death, resignation, removal, disqualification, or otherwise, may be filled by the Board for the unexpired portion of the term.

SECTION 5. *The President.* The President shall supervise the business and affairs of the corporation, subject to the general policies of the Board. He shall preside at all meetings of the Board. He may sign, with the Secretary or any other officer of the corporation authorized by the Board, contracts or other instruments which the Board has authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the Board or by these Bylaws to some other officer or agent of the corporation, or shall be required by law to be otherwise signed or executed. In general, he shall perform all duties usual to the office of President, and such other duties as may be prescribed by the Board from time to time. He shall be an ex officio member of all committees, standing or special.

SECTION 6. *The Vice-President.* The Vice-President shall perform the duties of the President in the event of the absence, incapacity, resignation, or death of the latter. When so acting, he shall have all the powers of the President. He shall also perform any other duties which are usual to the office, or assigned him by the President or the Board.

SECTION 7. *The Secretary–Treasurer.* The Secretary–Treasurer shall, in his capacity as Secretary, keep the minutes of the Board meetings in books provided for that purpose; see that all notices are duly given in accordance with the provisions of these Bylaws, or as required by law; be custodian of the corporate records; and in general perform all duties usual to the office of Secretary, and such other duties as from time to time may be assigned to him by the President or by the Board.

In his capacity as Treasurer, the Secretary–Treasurer shall, if required by the Board, give a bond for the faithful discharge of his duties in such sum and with such surety or sureties as the Board shall determine. He shall have charge and custody of, record, and be responsible for all funds and securities of the corporation; receive and give receipts for moneys due and payable to the corporation; and deposit all such moneys in the name of the corporation in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of CHAPTER FOUR of these Bylaws. He shall in general perform all duties usual to the office of Treasurer, and such other duties, consistent with his office, as from time to time may be assigned to him by the President or by the Board.

SECTION 8. *Executive and Administrative Personnel.* The Board may employ such executive and administrative personnel as it shall from time to time determine. The Board shall fix their compensation, and other terms of employment, and shall from time to time determine the titles by which such personnel are to be known.

CHAPTER FOUR

CONTRACTS, LOANS, CHECKS AND DEPOSITS

SECTION 1. *Contracts.* The Board may authorize any officer or officers, or agent or agents, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the corporation, and such authority may be general or limited.

SECTION 2. *Loans.* No loans shall be contracted on behalf of the corporation, and no evidence of indebtedness shall be issued in its name unless authorized by a resolution of the Board. Such authority may be general or limited.

SECTION 3. *Financial Instruments.* All checks, drafts, or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the corporation, shall be signed by the officer or officers, agent or agents of the corporation, determined by resolution of the Board.

SECTION 4. *Deposits.* All receipts of the corporation shall be deposited from time to time to the credit of the corporation in such banks or other depositories as the Board may determine, or may be invested if the Board so authorizes.

CHAPTER FIVE

COMMITTEES; ADVISORY COUNCIL

SECTION 1. *Executive Committee.* The Board may by resolution establish an executive committee which may exercise the powers of the full Board, between meetings of the latter. The executive committee shall report its actions to the full Board.

SECTION 2. *Other Committees.* The Board may by resolution establish other standing or special committees and determine the size, membership and functions of such committees consistent with the Articles and Bylaws of this corporation and with the laws governing this corporation. The President may appoint special committees whose functions do not duplicate or conflict with those of other committees, but the terms of such committees shall not extend beyond his term in office.

SECTION 3. *Advisory Council.* The Board may create an Advisory Council to assist it in the formulation of policies for the corporation and mechanisms for their implementation. The general officers of the corporation shall be ex-officio members of the Advisory Council.

CHAPTER SIX

FISCAL YEAR

The fiscal year of the corporation shall begin on the first day of January, and shall end on the last day of December in each year.

CHAPTER SEVEN

SEAL

The corporation shall adopt a seal on which its name and the state of its incorporation shall appear.

CHAPTER EIGHT

RULES OF ORDER

The then current edition of Sturgis, *Standard Code of Parliamentary Procedure* shall govern the proceedings of all meetings of the Board of this corporation.

CHAPTER NINE

INFORMAL ACTION BY DIRECTORS

Any action required by the Wisconsin Nonstock Corporation Law to be taken at a meeting of Directors of the corporation, or any action which may be taken at a meeting of the Directors or of a committee of Directors, may be taken without a meeting if a consent in writing setting forth the action so taken, shall be signed by all of the Directors or all of the members of the committee of Directors, as the case may be.

CHAPTER TEN

AMENDMENTS

These Bylaws may be amended or repealed and new Bylaws may be adopted at any meeting of the Board by a three-fourths (¾) affirmative vote of the Directors then in office; provided the substance of such proposed change was included in the notice of meeting; and further provided, at least one Director from each organization choosing two or more Directors under CHAPTER TWO hereof shall have voted in favor of such amendment, repeal, or new bylaw.

To train the doctors of tomorrow, medical education needs your help today

Give to the school of your choice through AMA-ERF

AMA-ERF

American Medical Association
Education and Research Foundation
535 N. Dearborn Street, Chicago 10, Illinois

DOCTORS! IS YOUR HOBBY PHOTOGRAPHY?

If so, then you'll want to enter the Annual Photography Contest sponsored by the State Medical Society of Wisconsin in conjunction with its annual meeting in May in Milwaukee.

The contest—**fotos/72**—is open to all members of the Society. Winning photographs will receive awards and be displayed at the Annual Meeting Exhibit Area. Details of **fotos/72** appear on page 25A of this issue.

ACCREDITATION MANUAL FOR HOSPITALS

Published by the Joint Commission on Accreditation of Hospitals (JCAH) in 1971, the manual is available as a loose-leaf binder edition for $8.00 (includes updating service through 12–31–72); or a soft-cover edition for $2.25. Explains the new JCAH STANDARDS for hospitals that became effective July 1, 1971. Special attention is given to emergency departments and the way that patients are handled. Although the new STANDARDS do not require all hospitals to have an emergency department, they must have a well-defined plan for emergency care based on community need and hospital capability. STANDARDS give minimum policies and procedures for both hospitals and medical staffs. Mandatory medical records on all emergency patients must be reviewed regularly to evaluate the quality of care provided in the emergency department. For copies: Write to JCAH, 645 North Michigan Ave., Chicago, Ill. 60611.

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Health Information—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Drug Abuse, Health Careers, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

Interested in a Working Vacation Abroad?

Some of the major organizations sponsoring volunteer physicians abroad are listed here for the benefit of Wisconsin physicians wishing to spend vacations in other countries where their medical knowledge and help are needed. Interested physicians should contact directly the sponsoring organization of their choice for further information.

- **Volunteer Physicians for Viet Nam,** 535 North Dearborn St., Chicago, Ill. 60610.
- **Project HOPE,** The People-to-People Health Foundation, Inc., 2233 Wisconsin Ave., Washington, D.C. 20007.
- **AmDoc, Inc.,** 27 E. Cannon Perdido St., Santa Barbara, Calif. 93101.
- **FOCUS, Inc.** (Ophthalmologists), 1431 Ashland Ave., River Forest, Ill. 60305.
- **Project Concern, Inc.,** P.O. Box 2468, San Diego, Calif. 92112.
- **Medical Assistance Programs, Inc.,** Box 50, Wheaton, Ill. 60187.
- **Catholic Medical Mission Board,** 10 W. 17th St., New York, 10011.
- **Christian Medical Council for Overseas Work,** National Council of the Churches of Christ in the USA, 475 Riverside Dr., New York 10027.
- **World Brotherhood Exchange,** Lutheran Council in the USA, 315 Park Ave. S., New York 10010.
- **Operation Crossroads Africa, Inc.,** 150 Fifth Ave., New York 10011.
- **MEDICO,** Orthopaedics Overseas Division, 2007 Eve St., NW, Washington, D.C. 20006.
- **Holidays for Humanity, Inc.,** 3700 Bellemeade Ave., Suite 105, Evansville, Ind. 47715.

THIRTEEN AIDS IN AVOIDING LAWSUITS

In a recent article in *Resident and Staff Physician* (June, 1970), Gene Balliett, president of a management consultant firm, presented thirteen points to aid in avoiding a malpractice suit. Once professional liability insurance has been bought and the policy carefully read, the following steps are recommended when problems arise with a case:

1. **Alert your insurer.** Notify him as soon as an accident occurs, instead of waiting until you receive notice of an impending lawsuit.
2. **Keep your insurance coverage to yourself.** Do not invite a malpractice suit by announcing to others the extent of your insurance coverage.
3. **Admit an honest mistake—but not legal liability.** Admitting an honest mistake is not the same as assuming liability. A court of law is responsible for determining liability.
4. **When you do err, avoid the risk of making an even bigger error—that of trying to cover up.** Even after making an error, continue to practice good medicine. A court may forgive an honest mistake, but usually will not rule favorably if a mistake is compounded by an effort to cover it up.

   For guidance with a specific case, the best initial source of advice is your professional liability insurer.
5. **Refer the plaintiff's attorney to your own.** Allow the lawyers to talk together, with the physician staying out of the conversation as much as possible.
6. **If a case doesn't go quite right, think twice about turning the patient's account over for collection.** Employing a collection agency often is the action which finally pushes a patient into bringing charges against a physician.

Additional suggestions in avoiding a lawsuit include:

7. **Learn to recognize a suit-prone patient.** Special care should be taken with patients who show an over-concern with money, unusually pointed criticism of one or more previous doctors, suspicion, and an unrealistic expectation of good results.
8. **Proceed only with a patient's informed consent.** A physician cannot legally proceed unless informed consent is obtained from the patient.
9. **Practice within the limits of your competence.** If a physician presents himself as a specialist, he must practice as a competent specialist.
10. **Be slow to guarantee a good result.** If care is taken while discussing a case or procedure with a patient, there is less chance of being held for breach of oral contract.
11. **Keep good records.** Extensive, accurate records are a necessity if a case is brought to court.
12. **See a case through once you start.** Once a physician begins to see a patient, he cannot abandon him without being held responsible for him.
13. **Head off assistant's errors.** The physician is responsible for anything done by anyone who works for him.

Anatomical Gifts—The Uniform Law

WISCONSIN, along with some 40 other states, has adopted the Uniform Anatomical Gift Act, a law under which a donor may leave all or any part of his body for research or transplantation. With the continuing publicity given to transplant technology you can anticipate an increasing number of inquiries on the Uniform Anatomical Gift Act and how your patients can make anatomical gifts. Some typical questions you will face and their answers are:

1. May I leave my body to medical sciences?

Yes. The Uniform Anatomical Gift Act permits you to make this disposition of your body after your death if you are over 18 and of sound mind.

2. Is there a need for such gifts?

Certainly. The need is two-fold, medical research and transplant materials. The training of physicians and research into the cause and cure of human ills requires hundreds of bodies each year. New techniques in transplantation make nearly every person a vital source of needed replacement parts for others.

3. Must I give my entire body?

No. You may decide whether to give your entire body, parts of it and what parts. Because of illness or donor condition, needs at the time of donor's death and the state of technology certain parts may not be usable if donated. It is suggested that the best gift is of the entire body so the needs at the time of its use can dictate how it can best advance health care.

4. Is there any pay to me or my estate for an anatomical gift?

No.

5. How do I make an anatomical gift?

It may be made by your Will or by a separate document. Since a Will may remain unread for some period after an individual's death, it is best that a separate document be used even if a gift is contained in the Will. A sample wallet card, fully legal under the Uniform Act, is printed at left. It must be signed by the donor and two witnesses. It need not be delivered to a doctor, hospital or medical school to be effective.

6. Can I revoke or change the gift?

Yes. If the gift is by Will, you may change your Will. If it is by separate document, you may destroy it and sign a new one (or sign none). If the document has been delivered to a doctor or other donee, a document (delivered or not) revoking or changing the gift or an oral statement with witnesses can accomplish this.

7. Does anyone else have a say in this?

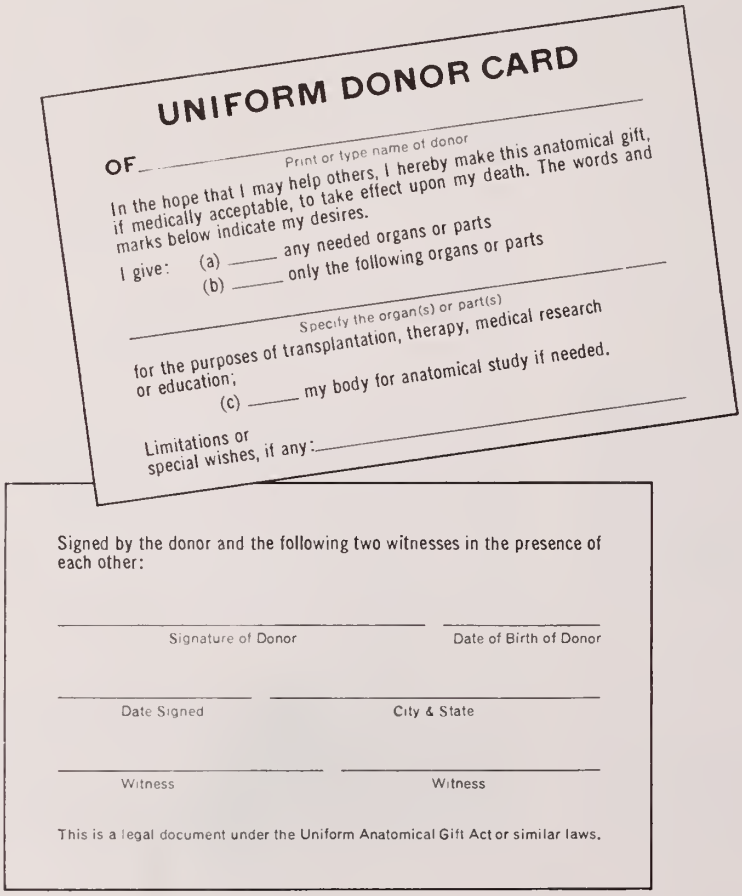
Yes. A body may be donated by a decedent's relatives if the deceased has made no objection to this while alive. The parents of a minor donor or the surviving spouse of any donor may revoke the gift. The body must be made available for last rites if the family requests this.

8. If I am killed accidentally, or die away from home, how will people know of the gift?

If you decide to make an anatomical gift you should carry an executed wallet card like the sample with you at all times. Also, the State of Wisconsin recently passed a law permitting anatomical gift donors to put an indication of the gift on their drivers' licenses. Decals for this should be available soon.

Further information relating to donation of bodies for medical research purposes can be obtained from the Department of Anatomy, University of Wisconsin Medical School, 1300 University Avenue, Madison, Wis. 53706; or from the Department of Anatomy, The Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis. 53233.

Regarding the donating of eyes, inquiries may be directed to the Milwaukee Eye Bank, 763 North 18th Street, Milwaukee, Wis. 53233.



UNIFORM DONOR CARD

OF _____
Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires.

I give: (a) _____ any needed organs or parts
(b) _____ only the following organs or parts

_____
Specify the organ(s) or part(s)

for the purposes of transplantation, therapy, medical research or education;
(c) _____ my body for anatomical study if needed.

Limitations or special wishes, if any: _____

Signed by the donor and the following two witnesses in the presence of each other:

Signature of Donor — Date of Birth of Donor

Date Signed — City & State

Witness — Witness

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

HOW TO GET HELP..... for a NARCOTIC ADDICT in WISCONSIN

GUIDELINES FOR ACTION

On November 8, 1966, Congress passed the Narcotic Addict Rehabilitation Act. This law provides for a 42-month treatment program initiated through the federal courts and implemented by inpatient hospital facilities and aftercare agencies. It is currently the only comprehensive program in the state dealing with narcotic addict rehabilitation. While individual hospitals and social services handle drug abusers, most do not provide separate professional treatment programs. These guidelines for action therefore apply to the NARA program in Wisconsin and show how professionals and others can best utilize it.

NARA

The law provides for four phases of admission and treatment. **The first phase,** commitment through the federal court, creates the legal force compelling the applicant to remain in treatment and aftercare after he has been accepted into the program. **The second phase,** following court referral, is Examination and Evaluation (E&E). It consists of a medical determination that the applicant to NARA is indeed a narcotic addict and amenable to rehabilitation. **The third phase,** inpatient hospitalization and rehabilitation, can last up to six months. The inpatient facility contracts with the National Institute of Mental Health—the sponsoring federal agency—to provide a range of medical and psycho-social rehabilitative services. **The fourth and final phase** is aftercare counseling and urine surveillance undertaken in the patient's home community. Again, an agency (or individual) contracts with NIMH to provide individual and group counseling, vocational counseling, referrals to existing state agencies, weekly urine analysis, and, in general, community reintegration. This phase may take three years. Any return to narcotics is cause for return to inpatient treatment, although this is at the discretion of the aftercare agency. Since the NARA patient is under court commitment, any unauthorized leave is cause for enforcement action. The comprehensiveness of the program maintains continued clinical contact with the recovering addict during the hardest months of readjustment.

THE FOLLOWING STEPS SHOULD BE TAKEN TO DETERMINE IF AN INDIVIDUAL CAN QUALIFY FOR THE NARA PROGRAM:

(1) Determine if the person has been using narcotic drugs as defined in the federal statutes; e.g., cocaine, coca leaves, codeine, dihydrocodeinone (Dicodid®, Hycodan®), dihydromorphinone (Dilaudid®), heroin, meperidine (Demerol®), methadone (Dolophine®), morphine, opium, and paragoric. Only narcotic drugs such as these and related drugs qualify the person for NARA treatment. Note that the federal statutes still classify cocaine and coca leaves as narcotics although they are pharmacologically stimulants; recent Wisconsin legislation removed these from the narcotic category.

(2) Determine if local, county, state, or federal charges are pending or held against the addict. Emphasize that this is not for enforcement purposes but only to determine for which of three titles the addict is eligible. **IN NO CASE WILL DETERMINATION OF BEING NARCOTIC DEPENDENT OR COMMITTED TO NARA BE CAUSE FOR CRIMINAL ACTION.** For purposes of clarification, there are three titles to the NARA act. Titles I and II deal with persons charged with federal offenses and convicted of federal offenses. Most of these criminal-addicts are dealt with by corrections officials; professionals contacting these addicts should inform them of the NARA treatment option. Title III is the

most widely used segment of the Act. It involves treatment of 'voluntary' committed civil cases. The following guidelines therefore refer to narcotic dependent persons in non-federal cases.

(3) Determine if the applicant to NARA has been previously treated under Title III. Too many previous civil commitments may disqualify him.

(4) If the applicant has local, county, or state charges pending against him awaiting final determination; or if he is on probation; or if any time remains on parole or mandatory release, then the following procedure should be followed:

(a) If criminal charges are pending, contact the defense lawyer and the prosecuting attorney, inform them of the NARA option, and ask them to urge either dismissal of charges (with the understanding that the defendant will undergo NARA treatment) or putting the defendant on probation after he pleads guilty. (The state courts have discretion; i.e., they are not bound to commit anyone to NARA).

(b) If the person is convicted but if his pre-sentence investigation is being conducted, contact the probation officer doing the investigation; inform him of the NARA option; discuss the addict's social history and character with the officer to show how treatment would be the most beneficial option; urge that the officer suggest NARA and probation rather than incarceration.

(c) If the person is on probation or parole or mandatory release, contact the probation officer; inform him of the NARA option; obtain his formal consent for the person to enter NARA.

It must be understood that the law technically states that commitment under Title III cannot be made a condition of parole or probation. Other arrangements between the courts, the probation officer, and the NARA applicant can be made.

Civil Commitment Procedure for Voluntary Applications

For service agencies contacted by addicts free of criminal charges, the following procedure is adopted directly. While leverage can be gained in step 4 through the threat of criminal prosecution or detention, voluntary applicants must be motivated in different ways. It must be stressed that narcotic dependent persons, like alcoholics, are masters at convincing people—and especially themselves—that they can handle the drug problem without outside help. The professional must thoroughly test every rationalization the addict offers as to why he is not suitable for the program. Help from ex-addict or related groups or individuals may be very useful. The civil commitment procedure is as follows:

(5) Contact the Wisconsin Correctional Service (436 W. Wisconsin Avenue, Milwaukee, 414:271–2512), a community-supported counseling agency that currently holds the only NARA aftercare contract in Wisconsin; or the **Bureau of Alcoholism and Drug Abuse** (1 W. Wilson Street, Madison, 608:266–2717). Superintendents of the two state hospitals can also provide information. These facilities can advise you and send professional counselors, if needed.

(6) Contact the **federal district U.S. Attorney's Office** nearest you and explain the person's situation to the Attorney. In the Western District, contact the office of U.S. Attorney John Olson in Madison (608:256–4441; ext. 4568); and the office of U.S. Attorney David Cannon in Milwaukee, the Eastern District (414:224–3381). Upon completion of this move, the Attorney determines if there is cause to assume that the applicant is an addict; he then petitions the federal court on behalf of the applicant.

(7) The federal court will, in effect, summon the applicant and his lawyer (or his court-appointed lawyer) to the court for two hearings. (A copy of 'Advice to Persons Desiring to be Treated Under Title III of NARA' is available on request from the Bureau of Alcoholism and Drug Abuse). The applicant is advised of his rights and the full extent of his obligations under the law; if he still wants to commit himself, he appears before the court again for temporary commitment to the E&E (Examination and Evaluation) phase.

(8) NARA pays for the medical and psychiatric evaluation done by the two physicians, one of whom must be a board-certified psychiatrist. If one or both of the physicians finds the person to be an addict and amenable to treatment, the addict has the option of scheduling another hearing to clarify his qualifications. If he waives this hearing, the court then formally commits him to an inpatient facility. Wisconsin Correctional Service is contracted to do E&E in Wisconsin and plans are being made to expand E&E to sites other than Milwaukee or Lexington. E&E may last up to 30 days.

(9) Until appropriate facilities are available in Wisconsin the six-month inpatient phase will take place at the Clinical Research Center in Lexington, Kentucky. Since January 1, 1967, when the National Institute of Mental Health assumed its jurisdiction, the CRC has changed from a detoxifying center to a more broadly-based treatment milieu and research center.

(10) Upon release the Wisconsin patient is referred to Wisconsin Correctional Service for aftercare follow-up. In addition to previously mentioned services, WCS helps pay for housing, medical, and other domestic expenses until the person secures employment or until WCS places him with existing service agencies. As the number of NARA clients grows, more aftercare agencies can develop, thus providing a more comprehensive state-wide program.

If the above procedures are inappropriate or undesirable, there are drug abuse treatment resources in Wisconsin which may be able to provide alternate treatment programs:

A-Center, Racine (414:637–8319)

Bellin Hospital, Green Bay (414:437–9031)

Columbia Hospital, Milwaukee (414:964–5100)

DePaul Rehabilitation Hospital, Milwaukee (414:281–4400)

Drug Abuse Clinic (Milwaukee Co. General Hospital), Milwaukee (414:258–2040)

Mendota State Hospital, Madison (608:244–2411)

Milwaukee County Jail Drug Detoxification Program, Milwaukee (414:271–4840)

Milwaukee Psychiatric Hospital, Wauwatosa (414:258–2060)

Shorewood Hospital, Milwaukee (414:964–0900)

Tomah V.A. Hospital, Tomah (608:372–4191)*

University Hospitals, Madison (608:262–1770)

Waukesha Memorial Hospital, Waukesha (414:544–2267)

Winnebago State Hospital, Winnebago (414:235–4910)

Wood V.A. Hospital, Milwaukee (414:384–2000)

* Addicted veterans can be treated through NARA or through the nearest V.A. hospital with the appropriate drug treatment facilities.

If none of these facilities are in your area and if you need further assistance, contact your Community Mental Health Clinic or the Division of Mental Hygiene district administrator. Because the problems of drug dependency are as complex and multi-faceted as those of alcoholism, professional coordination and referral is crucial. Like the alcoholic, the drug dependent person can be helped through community-wide cooperation.

For more information contact:

Bureau of Alcoholism and Drug Abuse
1 W. Wilson Street, Madison 53702
(608: 266–2717)

OR

Wisconsin Correctional Service
436 W. Wisconsin Avenue, Milwaukee 53203
(414: 271–2512)

Medical Malpractice:
A Legal Course for Doctors
Mar. 1–4 / Americana Hotel
Bal Harbour, Florida

IV Medical/Legal Institute
University of Miami Law Center
PO Box 8087
Coral Gables, Florida 33124

State Medical Society of Wisconsin

SPEAKERS SERVICE

for

COUNTY MEDICAL SOCIETY MEETINGS

and

COUNCILOR DISTRICT MEETINGS

County medical societies are urged to use this service which is now in its ninth consecutive year of operation. Speakers from throughout the state as well as those from the two medical schools and the State Division of Health are available through application to the State Medical Society. Applications must be filed at least 30 days before a meeting in order to qualify the speaker for an honorarium and travel expenses. (No speakers are furnished during April and May.)

All areas of scientific medicine are represented, and societies are urged to arrange for at least four scientific programs per year.

Other subjects on which speakers are available include legislation, health insurance, interprofessional meetings, school health, mental health, care of the aged, occupational health, medical press relations, maternal mortality, glaucoma detection, cancer and heart, orthopedic and heart clinics.

Request application forms from Gerald J. Derus, MD, Chairman, Commission on Scientific Medicine, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Sponsored by

COMMISSION ON SCIENTIFIC MEDICINE AND CHARITABLE, EDUCATIONAL AND SCIENTIFIC FOUNDATION OF THE STATE MEDICAL SOCIETY

in cooperation with

POSTGRADUATE PROGRAM OF MERCK SHARP & DOHME, WISCONSIN DIVISION OF HEALTH, AMERICAN CANCER SOCIETY—WISCONSIN DIVISION, THE MEDICAL COLLEGE OF WISCONSIN, AND THE UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

TIPS FOR THE IDENTIFICATION OF DRUG ABUSERS

The following chart was adapted by the Suffolk County Medical Society from one prepared by the Suffolk County District Attorney's Office

Drugs Used	Physical Symptoms	Look For	Dangers
Glue Sniffing	Violence, Drunk Appearance, Dreamy or blank expression	Tubes of glue, Glue smears, Large Paper Bags, or Handkerchiefs	Lung/Brain/Liver Damage, Death through suffocation or choking, Anemia
Heroin, Morphine, Codeine	Stupor, Drowsiness, Needle marks on body, Watery eyes, Loss of appetite, Blood stain on shirt sleeve, Running nose	Needle or hypodermic syringe, Cotton, Tourniquet-string, Rope, Belt, Burnt bottle Caps or Spoons, Glassine envelopes	Death from overdose, Addiction, Liver and other infections due to unsterile needles
Cough Medicine containing Codeine and Opium	Drunk appearance, Lack of coordination, Confusion, Excessive Itching	Empty bottle of cough medicine	Addiction
Marijuana ("Pot," "Grass")	Sleepiness, Wandering mind, Enlarged pupils, Lack of co-ordination, Craving for sweets, Increased appetite	Strong odor of burnt leaves, Small seeds in pocket lining, Cigarette paper, Discolored fingers	Inducement to take stronger narcotics. Psychological dependence. Possible physical damage?
Hallucinogens: (LSD, DMT)	Severe Hallucinations, Feelings of detachment, Incoherent speech, Cold hands & feet, Vomiting, Laughing & crying	Cube sugar with discoloration in center, Strong body odor, Small tube of liquid	Suicidal tendencies, Unpredictable behavior, Chronic exposure causes brain damage
Stimulants: Amphetamines ("Pep Pills," "Ups")	Aggressive behavior, Giggling, Silliness, Rapid Speech, Confused thinking, No appetite, Extreme fatigue, Dry Mouth, Shakiness, Insomnia	Pills or capsules of varying colors, Chain smoking	Death from overdose, Hallucinations, Psychosis
Sedatives Barbiturates ("Goof Balls," "Downs")	Drowsiness, Stupor, Dullness, Slurred speech, Drunk appearance, Vomiting	Pills or capsules of varying colors	Death or unconsciousness from overdose, Addiction, Convulsions in withdrawal

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Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow also will be presented with the problem of what to do with the physician's narcotics. The Office of the Regional Director, Federal Bureau of Narcotics and Dangerous Drugs in Chicago, which has jurisdiction over the State of Wisconsin with respect to these matters, has approved the following procedures:

> "The deceased physician's unused government order forms and narcotic drugs should be disposed of as soon as possible. Unused government order forms (Form 2513) should be returned to the Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director in Chicago, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the drugs. No remuneration will be made for the drugs surrendered to the Bureau of Narcotics and Dangerous Drugs."

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the Wisconsin Pharmacy Examining Board, 110 North Henry St., Madison, Wis. 53703.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

Physicians' Guidelines for Delegation of Duties and Functions to Nurses

THE SOCIETY has been asked on a number of occasions whether a certain procedure could be performed by a nurse. Following are some guidelines for a physician to follow when he considers delegating some function, procedure or duty to a nurse.

Three general principles control delegation to nurses. They are:

1. A physician can lawfully delegate to nurses only those functions, procedures or duties which do not require the exercise of his professional judgment.
2. The nurse must have training and experience in the function, procedure or duty to be delegated by the physician.
3. All such functions, procedures or duties must be performed under the direction or supervision or upon the prescription of a physician.

A recent position paper issued by the AMA, in discussing the role of the nurse in providing health care, said: "Professional nurses by the nature of their education are equipped to assume greater medical service responsibilities under the supervision of physicians. . . . Increased utilization of the nurse will significantly contribute to the quality of medical care."

The "practice of medicine" has been described as the primary professional responsibility of the physician for the total care of his patient. Under Wisconsin law a physician is granted an unlimited license. This is legislative recognition of his comprehensive training and his corresponding professional responsibility. Nurses are not granted such a license nor are they trained for such an overall responsibility. It should not be necessary to reiterate that a nurse cannot "practice medicine", or that a physician cannot, except in a genuine emergency, lawfully delegate the power to practice medicine to her wittingly or unwittingly. This is true even though the nurse is willing to perform a function that requires the exercise of the professional judgment of a physician.

The late Louis J. Regan, who was both a doctor of medicine and an attorney, speaking of industrial nursing, sums up the delegation question in the following words:

> "Authority to diagnose, treat, operate or prescribe cannot be delegated."
>
> LOUIS J. REGAN, *Doctor and Patient and the Law*, 3rd Ed., p. 484

Doctor Regan's text also contains the statement on page 483 that a nurse "should assume no responsibility for service outside the field of her professional training." A professional nurse's training is comprehensive in the field of nursing, but it does not encompass training for the practice of medicine. A nurse who is not trained in a procedure and does not have experience in it should not be allowed to perform it. Professional liability for her acts could attach to the physician who ordered a nurse to perform a procedure beyond her competence.

The training of nurses is divided into two levels. The longer and more comprehensive training leads to professional nursing and the lesser to practical nursing. These are separately defined in the Wisconsin Statutes. Section 441.11(1) of the Wisconsin Statutes defines "professional nursing", and Section 441.11(2) defines "practical nursing". These definitions are as follows:

> "441.11 Definitions. (1) Practice of Professional Nursing. The practice of professional nursing within the terms of this chapter means the performance for compensation of any act in the observation or care of the ill, injured or infirm, or for the maintenance of health or prevention of illness of others, which act requires substantial nursing skill, knowledge or training, or application of nursing principles based on biological, physical and social sciences, such as the supervision of a patient, the observation and recording of symptoms and reactions, the execution of procedures and techniques in the treatment of the sick *under the general or special supervision or direction of a physician*, the execution of general nursing procedures and techniques and the supervision and direction of trained practical nurses and less skilled assistants."
>
> "(2) Practice of Practical Nursing. The practice of practical nursing under this chapter means the performance for compensation of any simple acts in the care of convalescent, subacutely or chronically ill, injured or infirm persons, *or of any act or procedure in the care of the more acutely ill, injured or infirm under the specific direction of a nurse or physician.* A simple act is one which does not require any substantial nursing skill, knowledge or training, or the application of nursing principles based on biological, physical or social sciences, or the understanding of cause and effect in such acts and is one which is of a nature of those approved by the board for the curriculum of schools for trained practical nurses." (Italics supplied)

Note that in the definition of professional nursing a nurse can treat the sick only "under the general or special supervision or direction of a physician."

Similarly, attention should be given to the italicized wording in subsection (2), quoted above. It says, when read with the first part of the sentence, that "practical nursing" means *not only* sim-

ple acts in the care of convalescent and other specified persons, but also "*any act* or *procedure* in the care of the more acutely ill, injured or infirm under the *specific* direction of a [professional] nurse or physician."

The reasonable meaning of the above is that a practical nurse is not limited by statute to what is described in the first part of subsection (2). A trained practical nurse may *also* perform any act or procedure in the care of the more acutely ill, injured or infirm, *provided* she does so under the specific direction of (a) a professional nurse, or (b) a physician.

Some common sense considerations need to be observed, however. First, neither a physician nor a professional nurse can *lawfully* delegate to a trained practical nurse an act or procedure which would be legally improper for the professional nurse. Second, the phrase "specific direction" reasonably means *in the presence* and under the *immediate supervision* of the physician or professional nurse. This provides the safeguards indicated by the more limited training, skill and experience of the practical nurse.

However, neither type of nurse is authorized by the statutes to diagnose, operate or prescribe. Even the professional nurse can treat the sick *only* under physician supervision or direction.

Supervision or direction of a professional nurse by a physician can take many forms. Physical presence of the physician is not necessarily required in all instances. Many things are done upon the prescription of the physician. In this sense the prescription of a physician means a written order of a physician. This can be either a prescription as used in its normal meaning or an order written in the hospital or other charts.

In the last analysis, the matter becomes one of common sense of the physician, supplemented and guided by his professional training and experience and, equally important, by medical ethics and tradition.

Workmen's Compensation and the Physician

VIRTUALLY every physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury or illness sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or Ralph E. Gintz, Administrator of the Workmen's Compensation Division, Hill Farms State Office Building, Box 2209, Madison, Wis. 53701, if you have any questions.

Four points of advice will aid every physician in dealing with Workmen's Comp.:

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations (formerly the Industrial Commission). Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin.

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or Ralph E. Gintz at the addresses noted above.

RECENT WORKMEN'S COMPENSATION RULES

Effective Jan. 1, 1969, a physician or any other employer except a farmer is subject to the Workmen's Compensation Act if (1) he usually employs three or more employes or (2) he pays wages of $500 or more in any calendar quarter subsequent to July 1, 1968, covering services within Wisconsin.

An employer subject to the Act must have Workmen's Compensation insurance coverage, which can be obtained from any insurance company authorized to do such business within Wisconsin.

Serious penalties exist for failure to have insurance coverage. First, such failure is a misdemeanor and subject to fine of from $10 to $100 for each day of such illegal operation.

Second, the employer is personally responsible if one of the employes is injured while he is subject to coverage and is uninsured. Negligence by the employe is not a defense, and it need not be shown that the injury was caused by negligence of the employer.

A physician paying such wages need only obtain an insurance policy for Workmen's Compensation to comply with the law. The state Workmen's Compensation office is automatically notified of the issuance of the policy.

MUST A
Wisconsin Physician Report?

1. **Deaths?**
   The Wisconsin Statutes require that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there was no physician in attendance within 30 days preceding death.
   h. When a physician refuses to sign the death certificate.

   Violations of the above are punishable by fine or imprisonment.

2. **Treatment of automobile accident injuries?**
   No, unless there is a death.

3. **Drowning?**
   Yes.

4. **Gun shot wounds?**
   No, except where death results.

5. **Hunting accidents?**
   No, except where death results.

6. **Industrial accidents?**
   No, except where death results.

7. **Industrial diseases?**
   Yes, to the Division of Health, Department of Health and Social Services, for diseases as required by statute or regulation.

8. **Suicide attempts?**
   No; only death by suicide is reportable.

9. **Sending of corpses to undertaker?**
   Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. **Live births?**
    Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful.

    Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. **Communicable diseases?**
    Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. **Venereal diseases?**
    Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702. Patients delinquent in reporting for treatment must also be reported to the Division.

13. **Cancer?**
    Yes.

14. **Tuberculosis?**
    Yes, to your local Board of Health.

15. **Chronic alcoholics?**
    No, even if you know or believe it probable that they are driving automobiles.

16. **Epileptics?**
    No. But see article on page 68 of this issue.

17. **Drug addiction?**
    No.

18. **Abused children?**
    Yes. See article in January 1970 "Blue Book" issue of WISCONSIN MEDICAL JOURNAL at page 25.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The law prohibits a physician from disclosing, except as specifically required or authorized by law, any information which he acquired in attending a patient and which is necessary for him to treat that patient. Information provided to the Division of Health which relates to personal facts about a patient may be used only for statistical or summary purposes or anonymously except as its disclosure may be necessary to provide services for the patient.

Consent and Related Forms for Physicians

PREFACE

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; or tel. 608/257–6781.

Form numbers and titles as they appeared in 1970 are listed at the end of this article for easy reference when requesting such forms.

These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in 1970, and the text below have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in the January 1958 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL.

The forms do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1961*. The Society attorneys suggest that any forms that a physician might wish to use outside of the forms contained in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has published a text entitled *Consent Manual*. All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. What Is Consent

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed Consent

To be legally valid, an informed consent can be given only after the patient, or his parent or guardian, has an understanding of what is to be done and the risks involved. You, the physician must tell the patient, or his legal representative, in terms that he can understand, what you believe is necessary in his case. Then, you must tell him the risks that he will be taking if he follows your advice. The extent of disclosure of the risks is a matter of sound professional judgment.

b. Implied Consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is implied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. Who Can Consent

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

REPRINTS OF CONSENT AND RELATED FORMS

The forms referred to in this article are not being reprinted here since they did appear in the January 1970 "Blue Book" issue. If the January 1970 issue is not available, reprints of these forms can be ordered from the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; tel. 608/257–6781.

a. Minors

In Wisconsin, persons under the age of 21 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are three exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

The Juvenile Court for the County of a minor's residence may also give consent to the treatment and surgery wherever the minor petitions the Court for its consent.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a person is incompetent a consent will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies.

c. Persons under the influence of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

III. Why Consents

A physician who operates on a patient without authority commits an assault and battery on the patient. He may have to pay money damages to the patient, or he may even be subject to criminal fines and imprisonment.

Written consents, or oral consents given before witnesses, preferably non-involved, are the best proof that a physician can have to show that what he did was duly authorized by a patient.

A few minutes spent preparing, explaining and having the consent signed can save untold hours of time, money and embarrassment for the physician.

IV. Consents Limited

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a person who had no legal right to give it.

V. Consent and Related Forms

The text and suggestions that follow are related to the numbered forms that appeared in the January 1970 "Blue Book" issue. The form numbers and titles appear at the end of this article. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for Services

The physician–patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient–physician relation-

ship has been entered into the physician is under an obligation to treat the patient until the relationship is terminated.

2. Termination of Contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient–physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former Patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file.

b. Withdrawal from a Case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

He must give the patient proper notice that he is withdrawing from the case and must give the patient a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a Physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special Problems During Treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no protective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient Who Fails to Fallow Advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient Who Fails ta Keep Appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

c. Patient Who Leaves Hospital Against Medical Advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for their records.

d. Substitute Physician in Obstetrical Cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his office. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

e. Office Treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides

that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and Privileged Relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

a. Release of Medical Information

The State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly prepared an interpretation of the Wisconsin law concerned with examination of medical records. Any physician may request a copy from the State Medical Society. Its title is: *"An Interpretation of Chapter 301; Laws of 1959."* It has also been printed in the January 1968 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL beginning on page 45. The consent form set forth in that Interpretation is represented in the January 1970 "Blue Book" issue as Form 10.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs. Forms 11 and 12 may be used for this purpose.

c. Observers, Motion Pictures, Television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. Special Situations

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority.

1. Abortions

There are two types of abortion cases that are presented to physicians. Under Wisconsin law certain things need to be done, but they vary depending on the type of case.

a. Therapeutic Abortion

Wisconsin law recognizes the necessity for therapeutic abortions, but allows such an abortion only when three specific conditions have been met, namely:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

Form 16 should be signed by the three physicians in order to have a written record to meet the condition of Wisconsin law.

b. Recent or Partial Abortion

If a woman comes to you and asks you to treat an attempted or completed abortion, you should take reasonable precautions before treatment. The Wisconsin Supreme Court has stated that the following steps are proper for a physician to take:

1. insist on the presence of at least one other physician (not an associate) before treatment is given, or

2. when no other physician is available, insist on a written statement from the patient, in the presence of witnesses, if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

Form 17 can be used as a model for a statement by the patient.

Special Note: Portions of the Wisconsin Abortion Statute have been held unconstitutional by lower Federal Courts, but all of the cases invoking the Statute are still pending further disposition by the Courts. Until the matter has been clarified by the Courts or by new legislation, physicians would do well to follow the recommendations of the Council of the Society published in 1970.

2. Artificial Insemination

There are two types of artificial insemination. First where the husband's semen is used and, second, where the semen of a male other than the husband is used.

a. Artificial Insemination—Homologous

AIH involves the use of the husband's semen to attempt to make the wife pregnant. A consent should be signed by both the husband and the wife. Form 18 can be used for this purpose. It is believed there is no legal complication for this situation.

b. Artificial Insemination—Donor

AID involves the use of the semen of a male other than the husband. In such case there are persons other than the husband and wife to consider, namely, the donor, and if he be married, his wife.

The husband and wife must consent. Form 19 provides for this.

In this situation we also recommend that the donor and his wife execute consents such as Forms 20 and 21.

There is a diversity of opinion on the legality and morality of this type of artificial insemination. It is recommended that prior to the use of these forms each physician consult his personal attorney.

3. Sterilization

In Wisconsin, neither therapeutic nor non-therapeutic sterilization is a crime according to a 1968 opinion of the State Attorney General. Sterilization can result from three separate situations.

a. Sterilization As a Result of An Operation for Other Purposes

Some cases can result in sterilization, although the purpose of the operation is not to achieve sterilization. This risk must be explained to the patient in terms that he can understand. Then the physician should have the patient sign a separate consent form for this express purpose. Form 22 can be used for this purpose. The spouse should be urged to sign the consent. This is to avoid later statements by the spouse that he or she knew nothing about the possibility of sterilization.

b. Therapeutic Sterilization

Medical reasons exist for operations which are intended to sterilize the patient. In such cases a consent should be obtained from both the husband and the wife. Form 23 can be used for this procedure.

c. Non-Therapeutic Sterilization

Requests for non-therapeutic sterilization should be the subject of a conference with both the husband and the wife. The nature of the operation, the fact that it cannot be guaranteed as 100% effective, should all be explained in detail. Then, if they wish to proceed, a consent such as Form 24 should be signed.

VII. Other Consent Forms

Other forms not mentioned above, but which may be of common use to a physician, have been included in the January 1970 "Blue Book" issue of the Wisconsin Medical Journal. These forms are believed not to require explanatory text. Before they are signed, the physician should review the requirements for a valid consent given earlier in this article.

Form Numbers and Titles

The following form numbers and titles refer to the forms as printed in the January 1970 "Blue Book" issue of the Wisconsin Medical Journal and are listed here as an aid to ordering the forms from the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; tel. 608/257-6781.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.

Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.
Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

RECOMMENDED MINIMUM EMPLOYMENT STANDARDS FOR REGISTERED PROFESSIONAL NURSES IN WISCONSIN—Adopted and Approved October, 1970

Copies of this booklet are available upon request from the Wisconsin Nurses Association, Inc., 161 West Wisconsin Avenue, Milwaukee, Wis. 53203; or tel. (area code 414) 272–3670.

NARCOTICS

Annual Registration

All physicians are required to have a Bureau of Narcotics and Dangerous Drugs number (BNDD no.). The Regional Office of the Bureau in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee.

Change of Residence

If you move, or change your place or places of business, you must notify the Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604.

In Case of Death

The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's unused government order forms and narcotic drugs should be disposed of as soon as possible. Unused government order forms (Form 2513) should be returned to the Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director in Chicago, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the drugs. No remuneration will be made for the drugs surrendered to the Bureau of Narcotics and Dangerous Drugs."

Preprinted Prescription Blanks

The Justice Department, Federal Bureau of Narcotics and Dangerous Drugs, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which was printed in full beginning with page 45 of the January 1968 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL. If this issue is not available, copies may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701, or telephone 608/257-6781.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4).

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports, photographs, and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has *3* years within which to sue *for personal injuries*. If a patient elects to sue on *a contract* rather than for alleged *negligence*, he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there may be sound reasons for retaining them longer. No statute of limitation runs where fraud can be established.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization,

or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

The 1963 Legislature authorized the personal representative or the beneficiary of a life insurance policy to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Letters Testamentary" or "Letters of Administration" which are issued by the County Court, Probate Branch. In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) that the person signing the authorization is the beneficiary under the policy. The duty to provide the physician is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

Since no wording appears in the Statutes prescribing the form of authorization to inspect and copy a patient's record, except that the authorization must be "written", model forms are not recommended. Sample forms were included in "An Interpretation of Chapter 301; Laws of 1959" which appeared in the 1968 January Blue Book issue at page 45, but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

The 1971 Legislature has enacted a law permitting the County Court to order the release of medical records in personal injury cases. This law has not yet been interpreted by the Courts, so the breadth and application of the law are not yet clear.

AMA Ethics

The AMA has sent the following release to the State Medical Society. It is quoted in full for your information:

"Is it ethical for a physician, retiring from practice, to sell his patients' records to another physician?

"According to an opinion adopted by the AMA Judicial Council in November, 1967, a physician's records have been developed during the physician-patient relationship. This relationship, referred to in Section 9 of the *Principles of Medical Ethics*, requires that a physician not reveal the confidences entrusted to him in the course of medical attendance. Therefore, since the physician's records summarize these confidences, they too are cloaked with this same protection.

"The Council states further that a transfer of a patient's records, without his consent, would violate this confidence. However, with the patient's consent, his records may be transferred to a physician of his choice and a reasonable charge made for secretarial or duplicating services.

"Furthermore, the judicial Council declares that a physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician." (AMA News Release No. 13, February 1968)

TAX DEDUCTIBILITY OF HEALTH AND ACCIDENT INSURANCE

One-half of medical care insurance premiums up to a maximum of $150.00 are fully deductible. Additional medical care premiums may be included with other medical expenses and are subject to the limited deduction of the excess of medical expenses over 3% of adjusted gross income.

Premiums paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, are deductible medical expenses only to the extent allocable to medical care and *only* if the charge for medical care is separately stated in the policy or in a statement sent to the policyholder by the insurance company. In addition, the charge for medical care on a combination policy is eligible for a medical expense deduction only if not unreasonably large in relation to the total premium under the contract.

All taxpayers, whatever their age, are subject to the same general rules. The same rules as are set out above also apply for 1971 Wisconsin income tax purposes.

Control of LSD

The Wisconsin Legislature has added LSD and other hallucinogens to the list of "dangerous drugs."

Specifically, Lysergic Acid, LSD (lysergic acid diethylamide), DMT (N-N-Dimethyltryptamine), peyote, mescaline, psilocyn or psilocybin, or any salts, derivatives, compounds, combinations or mixtures thereof and any substances which are chemically identical with such substances have been added to the list of dangerous drugs which may be used by or distributed to the general public only when prescribed by a licensed physician or other person authorized by law to prescribe or distribute such drugs.

In addition to expanding the list of drugs, the Legislature has broadened the penalties for violations of the dangerous drug law. Illegal use of dangerous drugs or possession without intent to sell such drugs is punishable by not more than one year imprisonment or $500 fine or both for the first offense. Penalties for a second or any subsequent offense are imprisonment of not more than two years and a fine of not more than $1,000 or both.

More severe penalties have been created for certain classes of violators. Thus, a "supplier" who is convicted of illegal possession, sale, furnishing or transportation of any dangerous drug may be imprisoned not more than five years or fined not more than $5,000 or both. A supplier is defined by the statute as any unauthorized person who manufactures, sells or gives any dangerous drug defined under this section for the use of any person for whom such drug has not been prescribed by a practitioner or who in any way delivers such contraband material to anyone he intends to induce to become a user.

In addition, punishment of not more than five years in prison or not more than $2,500 fine or both has been created for any person who intentionally advises, induces or encourages, directly or by any other means, another to commit a violation of the dangerous drug law.

The burden of proving that one should not be prosecuted under the "dangerous drug law" because of an exception, excuse, proviso or exemption contained in the law has been placed on the defendant. This means that if arrested and tried for a violation of the dangerous drug law, a physician or pharmacist who dispenses such drug would be required to prove that he fits within an exception.

Reference: Section 161.30, Wisconsin Statutes.

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1972, you must pay the final installment of the estimated federal and Wisconsin tax on your 1971 income. This may necessitate an amended declaration by that date if you find that you underestimated 1971 income. A final income tax return for 1971, filed on or before January 31, 1972, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1971 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1971.
   (3) File fourth quarterly return for 1971 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1972, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Department of Industry, Labor and Human Relations.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1972 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1972. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1972. As to the final installment due in January, 1973, read the procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of four exception provisions following. (1) You pay an amount at least equal to the tax shown on your return for the preceding taxable year. This exception had been superseded during the period the Federal ten percent surcharge existed. Since repeal, this exception now exists again. (2) You may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (3) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (4) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms

may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary, Medical Examining Board, Department of Regulation & Licensing, State of Wisconsin, 110 No. Henry Street, Madison, Wis. 53703, in the month of January. This registration will be on a form furnished by the Medical Examining Board and should be accompanied by the registration fee shown on that form. Sec. 448.07, Wis. Statutes.

ANNUAL NARCOTICS AND DANGEROUS DRUGS REGISTRATION

All physicians are required to have a Bureau of Narcotics and Dangerous Drugs number (BNDD no.). The Regional Office of the Bureau in Chicago has informed the State Medical Society that it will notify all physicians when they must renew their number and send in the $5.00 application fee. If you move, or change your place or places of business, you must notify the Bureau of Narcotics and Dangerous Drugs, Room 1800, 219 South Dearborn Street, Chicago, Illinois 60604.

COMMITMENT REGISTRATION

Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 448.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (1) (b), Wisconsin Statutes.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service or moving to Wisconsin from another state *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to criticism or disciplinary action.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 448.02(1), 448.03(3), 448.16, Wisconsin Statutes.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Jewish Family & Children's Service, The Plankinton Bldg., Suite 3185, 161 W. Wisconsin Avenue, Milwaukee 53203.

Methodist Children's Services of Wisconsin, 303 Price Place, Lincoln Bldg., Madison 53711.

PUBLIC AGENCIES:

*Division of Family Services (See page 84 for list of Regional Offices).

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

LICENSED MATERNITY HOMES:

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19338 West North Ave., Brookfield 53005.

St. Francis Maternity Residence, 11th and Market Streets, La Crosse 54601.

Marian Hall, 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

* Nondenominational.

POISON INFORMATION CENTERS . . .

- approved by the Wisconsin Department of Health and Social Services, Division of Health, offer information on the chemical composition of brand-name products on a 24-hour day basis. Files are provided and kept up-to-date by the National Clearinghouse for Poison Control.
- recommend treatment to professional people or in certain emergencies, first aid procedure to lay callers.
- provide treatment for patients.
- keep a record of calls received, treatment advised or given, and disposition of case.
- report monthly to the Division of Health.

are located at:

Eau Claire
Luther Hospital
Phone: (715) 832–6611 Ext. 227

Green Bay
Bellin Memorial Hospital
Phone: (414) 437–9031 Ext. 257

Kenosha
Kenosha Memorial Hospital
Phone: (414) 656–2201

Madison
University Hospitals
Phone: (608) 262–3702

Milwaukee
Children's Hospital
Phone: (414) 344–7100 Ext. 308

POISON CONTROL CENTERS . . .

- exist in many hospitals, including those listed above as Poison Information Centers Not all Poison Control Centers are set up to give 24-hour service.
- provide treatment for patients.
- have standard references on toxicology and can answer many questions about potential poisons and treatment of cases. However, they do not have a complete file of the chemical composition of brand-name products such as the Poison Information Centers have.

This information provided by the
WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH
P. O. Box 309 Madison, Wis. 53701

Charitable, Educational and Scientific Foundation
of the State Medical Society of Wisconsin

Life is short . . . Art is longing . . . Experience is difficult

THE SYMBOL of the Charitable, Educational and Scientific Foundation of the State Medical Society contains one of the first recorded admonitions of Hippocrates to fellow physicians about medicine. The Greek letters are translated above. The staff and serpent is the traditional medical symbol, taken from the rod carried by the Greek god of medicine Asklepios (Roman Aesculapius).

The activities of the Charitable, Educational and Scientific Foundation encompass the wide scientific, educational, charitable and social commitments of its chief sponsors—the members of the State Medical Society of Wisconsin.

The Foundation was created in 1955 to permit members and other friends to present gifts or grants to projects vitally affecting medicine and public health. Its initial fund was used for student loans, but the Foundation's scope of interest has grown with the increased volume of financial contributions to worthy projects.

STUDENT LOANS

Since its inception, the Student Loan Program has helped students prepare for careers in medicine, nursing, dentistry, pharmacy and allied health fields. All loan applicants are required to be enrolled in an accredited school. Foundation loans are long term, low interest, and are interest-free until after the student's graduation.

Funds for these loans have been given to the Foundation to administer according to the wishes of the donors. Several of the loan programs have been set up by county medical societies for students from within that county. The Foundation establishes new loan funds at donors' requests.

CHARITABLE ASSISTANCE

Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues in need. The number of those who have called for help in cases of severe disability or financial insecurity is not great, but when assistance is requested by a physician or his widow, the Foundation's response is vital. What the Foundation has done in these cases has reflected the medical profession's generosity in helping its own.

MEDICAL STUDENT EXTERNSHIP PROGRAM

A newer Foundation project which has been highly successful is the Freshman Medical Student Summer Externship Program. It provides a ten-week externship with a family physician for students who have completed their freshman year of medical school.

Developed in cooperation with the Wisconsin Academy of General Practice, its principal purpose is to provide experience in the primary sector of medicine at an early stage in the student's medical career. In addition to providing a broad understanding of the role of the physician in the community, it is hoped this project will encourage students attending Wisconsin medical schools to establish their practices in this state when their education is completed.

Participating students receive fellowship grants from the Foundation, drawn from contributions by physicians, hospitals, Wisconsin Physicians Service-Blue Shield, Surgical Care-Blue Shield, American Family Insurance and the Wisconsin Rural Rehabilitation Corporation.

MUSEUM OF MEDICAL PROGRESS

One of the most extensive, on-going public health education efforts in Wisconsin has been made possible by the Foundation's development of the Museum of Medical Progress and Stovall Hall of Health at Prairie du Chien.

The Museum reaches out to the public not only with the story of medicine's past, but also with illustration and interpretation of its rapidly changing present.

Through the Medical Society's Academy of Medical History, the Foundation has acquired medical memorabilia from countless individuals in the state and has used these in numerous museum displays.

A message of medical and scientific achievement is presented directly to increasing numbers of museum visitors each year and, through publicity, traveling exhibits, and speakers to many thousands more.

RESEARCH ACTIVITY

Research projects on a variety of topics have been done with Foundation support. The Foundation is available to assist in planning, administering and funding investigations of a scientific or medical socio-economic nature.

Past projects have included studies of the relationship between hearing loss and systemic disease (diabetes, coronary heart disease, etc.), the cardiac worker in industry, and the health care of the aged. Any project worthy of pursuit is carefully considered by the Foundation Trustees.

SCIENTIFIC MEDICINE

Scientific activity, in the form of postgraduate teaching programs, is a major thrust of the Foundation. Teaching programs for physicians and allied health personnel, implemented through the Foundation, now involve hundreds of M.D.'s annually.

Among these programs are a Speakers Service to county medical societies, regional "in-depth" programs, and special conferences and lectures on various medical subjects.

The Speakers Service is regarded as a vital means of bringing physicians in practice around the state the latest in scientific knowledge from Wisconsin's two medical centers, as well as from outstanding physicians located elsewhere in Wisconsin.

Each "in-depth" program is a day-long combination of discussions and lectures on a particular medical problem. Attending physicians receive credit for their participation from the American Academy of Family Physicians.

The Foundation also makes significant contributions to scientific education through conferences on the medical aspects of mental retardation, prematurity, the newborn, stroke and athletic injuries as well as maternal mortality institutes.

POLICY AND ADMINISTRATION

The Foundation is a non-profit, non-stock corporation under Wisconsin statutes.

Governing power is vested in a Board of Trustees composed of the Council and officers of the State Medical Society, one representative from each of the 54 component county societies and up to ten elected non-medical persons.

Although the membership of the Board of Trustees numbers over 90, the officers and executive committee constitute an efficient working body in governing the routine affairs of the Foundation.

The officers of the State Medical Society, the officers of the Foundation and certain appointed trustees constitute the Executive Committee of the Board. A meeting of the entire Board is held at least annually. Officers are elected at that time. The Executive and other committees meet periodically throughout the year.

The Foundation's organization insures continuing liaison at the county medical society level throughout Wisconsin and an integration with the governing body of the State Medical Society itself. Such an arrangement assures a personal and realistic approach to Foundation activities.

OPPORTUNITIES FOR GIVING

Gifts to the Foundation may take a number of forms: cash, life insurance, securities, land, books, instruments, stamp and coin collections, works of art, and other artifacts. Some physicians are making the Foundation a beneficiary of their wills.

Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor.

All contributions to the Foundation are deductible for income tax purposes.

STUDENT LOAN FUNDS

available from the Charitable, Educational and Scientific Foundation

STATE MEDICAL SOCIETY OF WISCONSIN

Here is a list of student loan funds designed to aid Wisconsin students in medicine, dentistry, nursing, pharmacy and allied medical fields. These loan funds have been donated by individual physicians, county medical societies, personal memorials, and from other sources. In some instances, the CES Foundation acts as administrator of loan funds for other organizations or institutions.

These long term, low interest loans usually are limited to $500 per semester for a total of three years and generally are granted only when other sources of aid are unavailable. No interest is charged until two years after graduation from the professional school in which the student was enrolled.

Your contributions to any of these or the start of new funds can help the Foundation serve more deserving young people. Your check should be made payable to the Charitable, Educational and Scientific Foundation, specifying the particular fund you are supporting.

The funds and their requirements are shown at the right.

Interested persons are urged to contact the Charitable, Educational and Scientific Foundation, Box 1109, Madison, Wisconsin 53701.

FUND	*FOR EDUCATION IN:*	*APPLICANTS MUST BE RESIDENT OF:*
General Loan Fund	Medicine	Wisconsin
Brown County Medical Auxiliary Loan Fund	Medicine Allied Medical Fields	Wisconsin
Dane County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Dane County
Grant County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Grant County
Green County Medical Society Student Loan Fund	Medicine	Green County
Jefferson County Medical Society Nursing Fund	Nursing	Jefferson County
Marinette County Medical Society Health Careers Loan Fund	Medicine Nursing	Marinette County
Outagamie County Medical Society Health Careers Loan Fund	Medicine Allied Medical Fields	Outagamie County
Trempealeau County Medical Society Health Careers Loan Fund	Medicine Dentistry Pharmacy Nursing	Trempealeau County
Charles H. Crownhart State Student Loan Fund	Medicine	Wisconsin
Quincy Danforth, MD, Medical Student Loan Fund	Medicine	Wisconsin
W. W. Hildebrand, Esq., Memorial Account	Medicine	Wisconsin
Reuben Knutson Student Loan Fund	Medicine	Wisconsin
Menominee County Loan Fund (Ruth Coe, RN)	Nursing and Similar Health Fields	Menominee County
Albert Popp, MD, Student Loan Fund	Medicine (Medical College of Wisconsin students receive priority)	No residency qualifications
Cyrus G. Reznichek, MD, Student Loan Fund	Medicine (UW Med. School & Northwestern Med. School) Dentistry (Marquette School of Dentistry)	Wisconsin
Barbara P. Sargent Memorial Nursing Loan Fund	Nursing	Wisconsin
Beverly Schuster Memorial Fund	Nursing or Paramedical	Racine County
Wisconsin Academy of Family Physicians Loan Fund	Medicine (For students planning to be general practitioners)	Wisconsin

PRINCIPLES OF MEDICAL ETHICS of the AMERICAN MEDICAL ASSOCIATION

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Adopted June 7, 1957

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by ss. 200.26 and 204.31 (3m) and by no other law relating to insurance unless such law is referred to in ss. 200.26 and 204.31 (3m) and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through May 1971.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in

its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

COMMENT: Reference Committee on Finances was authorized by the House of Delegates at May 1967 Annual Meeting.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district, and one delegate representing all of the scientific sections. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Health Information.
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

COMMENT: In May 1967, the House of Delegates changed the name of the Commission on Public Relations and Communications to the Commission on Health Information.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Health Information shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Health Information shall study, make recommendations, and implement approved activities to improve the distri-

bution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena.

COMMENT: In May 1967, the House of Delegates repealed Section 5 of Chapter VII and substituted the present wording.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of

the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

SEC. 7. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 7, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 8. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 9. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Sturgis Standard Code of Parliamentary Procedure.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds an unlimited license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society

may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III. Such resident members shall have the right to vote and hold office.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

CHAPTER XII

THE ACADEMY OF MEDICAL HISTORY

Membership in the Academy shall be composed of those interested in preserving medical history in Wisconsin. The Academy shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Academy and shall not exceed $10 per year. The Academy is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Academy shall be segregated, and expenditures from them shall be made under direction and supervision of the Academy, subject to approval of the Council

Special membership certificates may be issued to those who become members of the Academy, and displays may be developed by the Academy for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 450.11, Wisconsin Statutes.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Division of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Division of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 300 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

Wisconsin Work Week of Health

Business Overhead Insurance

WPS Protection

Films on Drug Abuse

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Professional Liability Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adell:
Tolentino, J. Q.

Algoma:
Ancheta, Valentino
Hopkins, R. G.
March, J. F.
Papendick, D. E.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Schroeder, Daniel J., Jr.
Whitiark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Habel, Theodor
Lambert, J. W.
McKenna, J. E.
Moemound, J. O., Jr.
Roth, E. J.

Appleton:
Anderson, J. G.
Belden, A. D.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cline, R. S.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Evangelista, T. L.
Fenion, C. E.
French, G. A.
Giffin, W. S.
Gmeiner, J. E.
Gomilla, S. G.
Graves, M. D.
Green, C. J.
Gross, H. T.
Grubb, W. B., Jr.
Gunderson, F. O.
Hale, William H.
Hamel, H. H.
Harris, J. S.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kinde, R. R.
Kitzerow, E. B.
Konz, S. A.
Kwaterski, Mitchell
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
Manesis, J. G.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, J. E.
Miller, E. J.
Mueller, G. F., Jr.
Murphy, J. E.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Peterson, L. F.
Piouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Reichle, R. I.
Richards, W. R.
Russell, J. H.
Ryan, T. A.
Santos, G. P.
Sargent, J. M.
Savage, G. W.
Siegrist, K. J.
Simenson, R. S.
Slette, D. R.
Sullivan, J. F.
Taylor, A. C.
Veum, J. S.
Ward, R. H.
Warren, J. L.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.
Zeiss, J. C.

Arcadia:
Lleva, F. E.
Yray, R. N.

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Brick, D. L.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Mercer, W. C.
Morrow, K. A.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O. G.

Baldwin:
May, J. A.
Olson, C. A.
Torkelson, L. B.

Bangor:
Ruppenthal, K. P.

Baraboo:
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Lewis, J. M.
Pearson, C. R.
Siebert, J. T.
Vangor, D. W.

Barron:
MacMillan, D. G.
Strang, C. J.
Whaley, R. C.

Bayside:
Meyer, J. O.

Beaver Dam:
Barajas, Rafael
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Cupery, S. G.
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Ehrhardt, A. A.
Erickson, N. W.
Funcke, Wm. E.
Glunz, P. R.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Molina, Rudolfo
Qualis, C. L.
Richards, W. G.
Ritzenthaler, D. O.
Rowan, T.
Schulz, N. H.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Villalobos, Enrique
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Danocup, R. J.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Giesne, O. G.
Gold, K. I.
Gunderson, R. H.
Hebble, W. M.
Jones, E. T.
Katz, Mayer
Lakritz, L. W.
Lang, T. J.
Lee, P. U.
Manning, T. A.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qui, F. L.
Salvador, F. E.
Scholten, W. A., Jr.
Schwaegler, R. R.
Springberg, J. C.
Thayer, R. A.
Tuftee, A. O.
Twyman, A. H.
Woodington, G. F.

Berlin:
Gimenez, A. R.
Koch, H. C.
Koch, J. C.
Osicka, S. R.
Seward, L. J.
Sievers, D. J.

Big Bend:
Raschbacher, J. L.
Zarbock, F. M.

Black Earth:
Foseid, O. F.

Black River Falls:
Aprahamian, Charles
Daniells, A. S.
Haniey, L. L.
Holder, R. L.
Krohn, Eugene
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Murphy, P. W.

Bonduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Boyceville:
Deleon, J. J.

Brillion:
DeArteaga, Julio

Brodhead:
Stuessy, M. W.

Brookfield:
Alberti, J. B.
Bemis, E. L.
Blackwood, J. S.
Bogle, W. C.
Dodds, W. J.
Fick, K. R.
Fitzpatrick, P. J.
Franzen, L. D.
Gager, W. E.
Gregorio, F. Q.
Gryniewicz, Michael
Hart, T. N.
Huizenga, B. A.
Jennison, M. R.
Kim, Y. W.
Laubenheimer, Roger
Lim, R. A.
Lipscomb, C. R.
Luedke, D. M.
Mann, D. H.
Meves, T. F.
Mueller, K. H.
Nemcek, A. A.
Olsen, R. N.
Pavlic, R. S.
Popp, M. J.
Roth, D. A.
Schaefer, K. C.
Seweil, R. H.
Stewart, W. C.
Stoklos, Michael
Teresi, J. L.
Tiu, A. L.
Toepfer, R. A.
Viel, R. S.
Vondrell, J. J.
Wells, R. K.
Wiesen, R. L.
Wood, D. L.
Wright, I. V.

Brown Deer:
Darling, W. A.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Raduege, W. E.
Whalen, M. L.

Burlington:
Baker, D. J.
Batsieer, R. L.
Erickson, L. W.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Cadott:
Zenner, C. E.

Caledonia:
O'Brien, M. J.

* As of Dec. 31, 1971.

Cambria:
Samadani, A. M.

Cambridge:
Nemec, George, Jr.

Campbellsport:
Hoffmann, L. A.

Casco:
Kerscher, E. J.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Fueridi, Adam
Huckaby, A. L.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Laufenburg, Herbert
Misch, Allen

Cedar Grove:
Jefferson, R. A.
Jensen, J. S.

Chetek:
Adams, R. W.
Bannister, F. M.
Bender, J. P.
Esswein, J. L.
Pierpont, D. B.

Chilton:
Humke, K. R.
Klein, M. H.
Knauf, J. W.
Lozada, R. E.
Ylagan, A. M.

Chippewa Falls:
Dahl, D. A.
Gonzaga, C. R.
Gonzaga, F. Q.
Graber, Rex E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Pili, D. B., Jr.

Clintonville:
Arnold, W. G.
Bate, L. C.
Belgado, P. G.
Caskey, H. S.
Solidum, R. R.
Topp, C. A.

Colby:
Koch, James W.
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Colgate:
Stein, R. W.

Columbus:
Cheli, C. F.
Poser, J. F.
Poser, R. F.

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Crivitz:
Settlage, H. A.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Lagman, R. M.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Abdallah, W. A
Armagan, Senekerim
Chelius, C. J.
Cornell, J. W.
Fine, J. M.
Fons, J. W., Jr.
Frederick, J. J.
Gomez, S. W.
Homsey, J. J.
Jan, Mazhar
Kash, S. H.
Lando, D. H., Jr.
Latorraca, Rocco
Marcich, Z. P.
Nunag, A. H.
Nuyda, D.
Palisoe, J. M.
Potos, W. B.
Rabor, A. A., Jr.
Sirin, K. F.
Tabet, R. C.
Vitulli, V. N.
Wadina, G. W.

Cumberland:
Anderson, R. M.
Goza, G. M.
Jirsa, H. O.
Lund, R. E
Riemer, D. E.

Darlington:
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Fitzgerald, G. P.
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.

De Pere:
Adamsky, V. D.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

Dodgeville:
Downs, D. R.
Rasmussen, N. G.

Dousman:
Dodson, V. M.
Goldstein, F. P.
Pecarski, Miodrag
Varma, Som D.

Durand:
Bryant, R. J.
Myers, M. E.
Springer, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

Ellsworth:
Jonas, E. R.

East Troy:
Kohn, Louis
Young, W. N.

Eau Claire:
Aitken, H. M.
Bates, P. J.
Bayley, Bruce
Beckfield, W. J.
Bjurstrom, R. O.
Blank, R. J.
Brousseau, E. R.
Brown, F. J.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Dibble, J. B.
Edson, J. D.
Fink, R. J.
Finucane, P. J.
Fitz, F. W.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Griben, L. R. J
Griffith, D. R.
Haag, A. F.
Halgrimson, K. W.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F.
Huston, H. C.
Ihle, C. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
King, B. J.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Manz, W. R.
Mautz, W. T.
McAfee, G. D.
Midelfort, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G
Sperry, V. A.
Stewart, K. E.
Strand, R. C.
Swanson, P. A.
Thimke, H. E.
Tobin, J. M.
Ullrich, P. H.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, C. E.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Lundstrom, J. H.
Mol, H. R.
Petersen, R. D.
Rawlins, J. A.
Rogers, R. J.
Schrock, J. B., Jr.
Sorenson, E. D.

Ellsworth:
Jonas, E. R.

Elm Grove:
Bauer, C. A.
Braun, J. E.
Denio, M. J., Jr.
DeVault, M. L.
DiMiceli, Ettore, Jr.
Dudenhoefer, P. A.
Erwin, C. J. R.
Erwin, C. P.
Foster, L. L.
Grade, J. O.
Headlee, C. R.
Klingbeil, R. E.
Kocovsky, E. C.
Mateicka, W. E.
McCormick, G. E.
Myers, S. C.
Olsen, E. H., Jr.
Redlin, R. R.
Rouman, W. C.
Schmidt, R. A.
Settima, A. L.
Shockley, B. F., Jr
Simerson, T. P
Sinclair, E. P.
Smits, R. H.
Van Gilder, J. H.
Wilson, S. D.
Wisniewski, J. H.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Shields, C. H., Jr.
Stupek W. S

Fish Creek:
Hogan, J. H

Fond du Lac:
Becker, N. O.
Benneyan, R. N.
Bissegger, Arnold
Borsack, K. K.
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Harman, B. H
Horn, E. B.
Huebner, J. S.
Hutter, A M.
Jones, L. E.
Jones, R. J.
Keenan, L. J.
Kendell, W. G.
Klef, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Licwen, B. E.
Longstreth, C. R.
Mauthe, Howard
McBride, F. F.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meisinger, G. F.
Moore, C. E.
Myers, W. E.
Nelson, D. L
Pallin, Josephine N.
Parrish, J. G., Jr.

Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schlichting, J. E.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R., Jr.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Sullivan, E. J.
Theis, E. H.
Theisen, S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J., Jr.
Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Weber, D. R.
Wler, J. S.
Wojta, W. C.
Yockey, J. C.

Ft. Atkinson:
Aufderhaar, H. W.
Bates, D. E.
Beran, F. V.
Gueldner, L. H.
Handeyside, R. G.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Moritz, W. D.
Roesler, M. J.
Russell, J. C.

Fox Point:
Peters, L. M.
Silberman, Jack

Franklin:
Atamdede, Aysel
Maleki, Massoud
Stein, P. G.

Franksville:
Gass, H. I.

Frederic:
Andrews, W. C.
Fischer, W. A.
Schwab, D. F.

Friendship:
Gascoigne, C. C.
Janssen, M. L.
Tamayo, Alfonso
Weihe, A. R.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Schofield, Raymond
Reyes, Metodio

Glendale:
Brazy, R. R.
Guten, G. N.
Mendeloff, Elton
Wegmann, G. H.

Glenwood City:
Limberg, A. W.
Limberg, P. W.

Grafton:
Pelant, K. F.

Grantsburg:
Hartzell, R. L.

Green Bay:
Adair, S. E.
Anderson, C. L.
Andrew, R. C.
Angus, D. C.
Austin, S. D.
Axenrod, Howard
Babbitt, L. D.
Belson, M. J.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Blahnik, C. L.
Block, R. T.
Boersma, J. J.
Bradke, D. L.
Bramschreiber, J. L.
Brusky, A. H.
Brusky, E. S.
Brusky, J. D.
Brusky, R. J.
Caffrey, J. F.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Cross, W. M.
Danaher, H. H.
Dega, F. J.
Denys, G. F.
Dettmann, J. E.
Donarski, D. F.
Draheim, J. H.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gallagher, D. J.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Green, J. R.
Griggs, S. L.
Gruesen, R. A.
Guthrie, J. M., Jr.
Haines, A. W.
Hart, L. E.
Hitch, O. M.
Hoops, H. J., Jr.
Jacobs, E. B.
Jensen, R. E.
Johnston, R. E.
Jones, W. D.
Kaftan, G. R.
Kaufman, J. E.
Kenny, J. A.
Killeen, E. R.
Killins, J. A.
Kuehl, F. O.
Kulkoski, Bernard
Kullerstrand, D. S.
Leicht, T. R.
Le Mieux, G. E.
MacMullen, Wallace, II
Manabat, Enrique
Marnocha, J. R.
Martin, J. E.
McCormick, R. A.
McGuire, G. E.
McIntyre, J. A.
McKenna, D. H.
McManus, J. T.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Mills, J. M.
Milson, B. I.
Milson, Louis
Milson, S. E.
Mokrohisky, J. F.
Murphy, R. J.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Nickel, F. A.
Nicolaus, W. H.
Nishioka, Hiro
Ottum, J. A.
Oudenhoven, R. C.
Peters, H. R.
Philipp, L. D.
Rahr, H. C.
Richardson, B. L.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Schneider, W. F.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Sipes, D. R.
Skarpol, D. P.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoehr, B. J.
Stoll, W. M.
Sullivan, Donel
Thearle, D. S.
Theiler, G. J., Jr.
Thompson, L. L.
Troup, C. W.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Utrie, J. W.
Von Helmburg, Roger
Walker, T. F.
Wallerius, J. F.
Wentworth, A. F.
Wineinger, D. M.
Wochos, R. G.
Zucker, K. L.

Greendale:
Anacleto, E. F.
Brown, R. J.
Coe, A. O.
Gabriel, R. P.
Herrington, R. E.
Kottke, M. A.
Kuglitsch, E. F.
Martins, R. R.
Spiegelhoff, D. R.
Taugher, P. J.
Wengelewski, H. B.
Westley, William, Jr.

Greenfield:
Weis, T. W.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Gresham:
Litzen, F. L.

Hales Corners:
Altstadt, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Gillespie, C. J.
Grosshandler, S. L.
Jachowicz, R. B
La Susa, T. J.
Liu, C. C.
Pagedas, A. C.
Pierce, D. F
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Bae, I. H.
Donahue, Parnell
Hoffmann, J. G.
Hoffmann, W. C.
Kern, T. J.
Mally, M. J.
Marasigan, A. Z.
Monroe, M. E.
Nickels, R. J.
Quackenbush, E. C.
Quandt, V. V.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Eder, R. L.
Hussa, J. F.
Sahs, M. H.
Sharp, D. S.
Strapon, Paul, III

Hazel Green:
Farbstein, M. E.
Klein, G. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.

Hollandale:
Delafuente, Eduardo
Marshall, S. B.

Horicon:
Karsten, F. A.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hubertus:
Holmburg, C. E.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.

Hurley:
Martinettl, D. J.

Independence:
Meyer, C. F.

Iola:
Hollero, N. J.

Iron River:
Edwards, P. K.

Jackson:
Albrecht, J. E.

Janesville:
Apfelbach, G. L.
Baker, C. S.
Betlach, Dorothy W.
Betlach, Eugene H.
Bostian, K. E.
Chicks, C. O.
Deeds, E. C.
Dodge, R. K.
Donkle, M. J.
Farnsworth, R. W.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Holland, R. A.
Job, E. J.
Kalember, R. L.
Karzel, R. P.
Knepel, Donald
Kochell, R. L.
Kronquist, G. E.
Lakritz, Amrum
Levin, Harland
Llewellyn, M. B.
Matzke, Robert F.
McNichols, E. F.
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nienhuis, H. D.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Otterholt, E. R.
Overton, R. S.
Papadakes, N. G.
Pember, J. F.
Peters, E. E.
Plautz, A. C., Jr.
Purdy, M. F.
Ram, V. A.
Rau, Esther L.
Reinardy, A. L.
Reinardy, E. W.
Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
Surkarati, Ebrahim
Schroder, John R.
Schroeder, Jack D.
Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Tregoning, P. C.
Vitacca, R. J.
Vogel, T. L.

Jefferson:
Busse, A. A.
Quandt, C. E.

Quandt, R. W.
Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

Juneau:
Haessly, F. G.
Heath, H. J.

Kaukauna:
Bachhuber, A. E.
Bachhuber, A. M.
Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Wolfmeyer, W. W.

Kenosha:
Ambro, P. J.
Armstrong, G. F.
Ashley, R. W.
Balcjunas, Vitoldas
Barnes, E. H., III
Barreto, R. S.
Bilak, R.
Bjork, H. A.
Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Cozine, W. I.
Creighton, L. H.
Creswell, C. M.
Cruz, N. R.
Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Fraser, W. E.
Gandhi, K. V.
Garren, J. T., Jr.
Goldstein, D. N.
Halfon, Nesim
Hauschild, W. A.
Heck, J. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Huberty, L. H.
Kappus, H. C.
Kim, Zaezeung
Kleinpell, W. C.
Lokvam, L. H.
Meeter, U. L.
Mercado, R. C.
Miller, David
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Nice, M. L.
Olsman, Louis
Pamukcu, F.
Pamukcu, Afet
Patel, A. P.
Pearson, J. B.
Pechous, C. E.
Pechous, C. E., Jr.
Peterson, C. E.
Powell, R. A.
Przlomski, A. T.
Rafferty, H. P.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Rufflo, A. F.
Sanson, J. G.
Sattler, C. A.
Savaglio, V. P.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Slegel, Morris
Swift, W. J.
Turner, Lewis, III
Wadina, G. S.
Wagner, H. B.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wilson, R. E.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
Lanier, A. S.
Lanier, Patricia F.
Nesemann, R. M.
Wits, E. W.

Kiel:
Theller, A. C.
Twohig, G. J.

Kimberly:
Buchanan, K. E.
Gage, Ralph S.
Knoedler, W. H.

King:
Damp, O. E.
McGinnis, H. J.
Skibba, J. P.

Kohler:
Forkner, W. A.
Rowe, D. M.

La Crosse:
Aiken, R. E.
Alvarez, Ubaldo
Anderson, N. P.
Anderson, P. D.
Annis, B. L.
Bach, A. C.
Biros, D. G.
Bogart, K. C.
Brailey, A. G., Jr
Britt, A. G.
Buchman, D. M.
Buie, T. E.
Caplan, R. H.
Carlsson, E. S.
Cejpek, K. O.
Clemons, J. E.
Comin, D. B.
Cook, A. A.
Copps, S. C.
Corser, D. H.
Da Costa, W. C.
Dalton, R. M.
Dietz, P. C.
Durst, J. B.
Edland, R. W.
Egan, G. J., Jr.
Ellenz, G. B.
Elston, A. C. V.
Ernst, F. W.
Felion, P. L.
Fisher, A. L.
Flynn, R. E.
Gallagher, F. J.
Gallagher, W. B.
Getz, Kaare
Gilbert, R. L.
Glasser, J. E.
Goodnough, D. E.
Green, R. M.
Guernsey, Gretchen
Gundersen, A. E.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, Cameron
Gundersen, G. A., Jr.
Gundersen, Gunnar
Gundersen, J. H.
Gundersen, S. B., Jr.
Gundersen, T. E.
Haidinyak, A. L.
Halbert, H. E.
Hartigan, J. M.
Haug, S. L.
Hayden, J. W.
Helliesen, P. J.
Henke, T. K.
Hickey, A. W.
Howard, R. S.
Jaeger, J. G.
Janis, J. F.
Kader, N. M. A.
Kalfayan, Bernard
Keimowitz, R. M.
Keller, K. E.
Kisken, W. A.
Leiby, R. W., Jr.
Link, C. E.
Lindesmith, L. A.
Locher, R. A.
MacEwen, A. R.
Mahairas, G. H.
Mansheim, B. J.
McGarty, M. A.
McKee, D. C.
McMahon, R. E.
Meis, P. J.
Midelfort, C. F.
Miller, C. H.
Miner, E. B.
Morgan, W. A.
Morris, D. L.
Murphy, J. T.
Natoli, C. A.
Newcomer, K. L.
O'Leary, Wm. J., Jr.
O'Meara, M. T.
Orman, E. S.
Overholt, E. L.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R
Roberts, T. N.
Rodman, C. A.
Satory, J. J.
Schaldach, F. A.
Scheurich, Mary B.
Schiebler, J. C.
Schmidt, C. F.
Schmidt, L. R.
Schneeberger, E. J.
Schuldes, R. E.
Seager, G. M.
Sevenants, J. J.
Severeid, L. R.
Shealy, C. N.
Shields, J. C.
Sierra, Jesus
Simones, J. J.
Skemp, C. A.
Skemp, F. C.
Skemp, G. E.
Skemp, J. J.
Skemp, J. T.
Skemp, S. J.
Slungaard, Rolv
Smiley, J. J.
Smith, Martin J.
Swingle, J. D.
Taebel, D. W.
Tankersley, J. C.
Tendero, R. A.
Terman, J. W.
Thompkins, D. G.
Traveilli, Ranato
Uhrich, G. I.
Vallejo, W. J.
Wahl, J. W.
Van Susteren, J. A.
Watunya, M. J.
Weeth, J. B.
Whiteway, R. E.
Winga, E. R.
Wolf, F. H
Yutuc, W. R.

Ladysmith:
Bauer, W. B. A. J.
Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

Lake Geneva:
Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
Jeffers, D. H., Jr.
Rauch, A. M.

Lake Mills:
Eck, G. E.
Effenhauser, Manfred
Leering, Hendrik
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lake Tomahawk:
Craite, E. J.

Lancaster:
Bauman, K. L.
Becher, L. E.
Carey, H. W.
Hillery, G. C.
Houghton, E. M.
Johnson, L. W.
McCay, Sophia

Land O' Lakes
Eickhoff, E. C.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Van Lieshout, F. X.

Lodi:
Irwin, W. G.

Loyal:
Hable, A. P.

Luxemburg:
Majeski, H. E.

Madison:
Abroms, G. M.
Ainslie, R. B.
Albright, E. C.
Albright, J. G.
Allen, J. R.
Allen, J. C.
Allin, R. N.
Amato, J. M. D.
Anderson, A. D.
Anderson, H. A.
Anderson, Jeanne
Andrew, R. B.
Andringa, C. L.
Ansfield, F. J.
Ansusinha, Tamnit
Appen, R. E.
Arnesen, R. B.
Ashman, H. C.
Babcock, S. W.
Backs, M. F.
Backwinkel, K. D.
Baker, R. M.
Bamforth, Betty J.
Barnes, H. P. G.
Barsch, J. H.
Barta, R. A., Jr.
Bartlett, W. H.
Batson, J. F.
Beck, J. P.
Becker R. M.
Biek, Richard
Beilman, R. L.
Belknap, E. L., Jr.
Benish, G. A.
Bennett, Maxine
Berg, Mary C.
Berger, J. V., Jr.
Bernard, F. D.
Bernhardt, L. C.
Bertelson, J. N.
Biek, Richard
Blackman, H. J.
Blancke, F. W.
Bloodworth, J. M. B., Jr.
Blum, F. G., Jr.
Bohlman, D. C.
Boldon, E. I., Jr.
Bonebrake, R. A.
Boone, M. L. M.
Botham, R. J.
Boyer, S. W.
Brandenburg, J. H.
Brew, Barbara A.
Brindley, B. I.
Britton, D. M.
Brodhead, Wm. T.
Brown, J. G.
Browning, T. H.
Brueggemann, J. G.
Bryan, G. T.
Bryant, D. G.
Buchler, Dolores A.
Burke, Mead
Burke, Myra E.
Byce, K. R.
Calloway, N. O.
Calvert, Charlotte
Carter, H. M.
Carter, T. L.
Celesia G. G.
Chambers, J. D.
Chase, S. L.
Chosy, L. W.
Chun, R. W. M.
Clausen, N. M.
Clinton, G. L.
Cohen, Marcus
Collins, R. F.
Cookson, D. U.
Cooper, G. A.
Coryell, J. L.
Cowle, A. E.
Crennell, E. H.
Crocker, L. G.
Crowell, Edward B., Jr.
Crowley, W. P., Jr.
Crummy, A. B., Jr.
Cunningham, M. A.

Curet, L. B.
Curreri, A. R.
Dahl, D. S.
Dally, A. D.
Daugherty, D. A.
Davenport, Gordon, Jr.
Davidson, P. L.
Davis, J. B.
Davis, F. J.
Davis, H. L., Jr.
Davis, M. D.
Dean, F. K.
Dean, J. L.
Demergian, Vaughn
Derus, Gerald J.
de Venecia, Guillermo
Dibble, P. A.
Dickie, Helen A.
Dieter, D. G.
Dimond, W. B.
Doehlert, C. A.
Donovan, T. J.
Doolittle, J. W.
Dortzbach, R. K.
Doshi, H. V.
Doty, J. W.
Dudiak, Stephen
Duehr, P. A.
Dunkelberger, L.
Ebling, P. R.
Eckert, G. L.
Ecklund, L. A.
Edwards, J. S.
Ehrlich, F. E.
Eichman, P. L.
Eiler, D. M.
Epstein, Stephan
Erickson, M. T.
Ewell, G. H.
Fabiny, R. J.
Farrell, R. X.
Fellner, C. H.
Fischer, L. C.
Forster, F. M.
Fosdal, F. A.
Fosmark, C. A.
Foster, M. A.
Foster, Ruth C.
France, T. D.
Frechette, P. F.
Froelich, R. D.
Ganser, L. J.
Garnett, G. M.
Gascoigne, J. T.
Geocaris, Konstantin
Geppert, C. H.
Geppert, T. V.
Giles, L. T.
Gladstone, H. P.
Glover, B. H., Jr.
Golden, F. F.
Golden, P. B.
Gollin, F. F.
Gordon, E. S.
Gordon, M. C.
Grab, J. A.
Graf, R. A.
Graham, D. T.
Grahek, A. S.
Grassy, R. G.
Graven, S. N.
Hahn, M. F.
Halleck, S. L.
Hamacher, J. E.
Handa, Yoshio
Handy, G. H.
Hank, G. C.
Hansen, M. F.
Harbour, J. D.
Harper, C. S.
Harper, S. B.
Hartridge, T. L.
Hassinger, J. T.
Havel, M. C.
Head, R. W.
Healy, J. R.
Heiden, J. D.
Henderson, R. R.
Hendricks, R. J.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hinck, V. C.
Hisgen, W. J.
Hobbins, W. B.
Hoff, A. D.
Hoffman, P. A.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Horswill, C. W.
Howe, G. E.
Huffer, J. M.
Hummer, F. L.
Hurst, D. W.
Hussey, J. L.
Hutson, C. F.
Iams, A. M.
Inhorn, S. L.
Jackson, C. R.
Jackson, R. H., Jr.
Jaeschke, W. H.
Jahn, C. L.
Janicek, D. R.
Javid, Manucher
Joachim, F. G.
Johnsen, A. F.
Johnson, E. E.
Johnson, R. O.
Johnson, S. A. M.
Johnson, S. B.
Jorris, E. H.
Juhl, J. H.
Kabler, J. D.
Kanner, A. V.
Kaskey, E. T.
Kaveggia, Laszlo
Keepman, Jay P.
Kemp, T. S.
Kennan, A. L.
Kiekhofer, William
Kilpatrick, Leslie G.
Klatt, K. M.
Knezevic, Ivan
Koenecke, F. H., Jr.
Koenig, E. F.
Kolner, E. H.
Kopp, W. L.
Koppa, J. F.
Korbitz, R. F.
Korst, D. R.
Kriss, Frederick C.
Kroncke, G. M.
Krout, R. M.
Kundert, P. R.
Kunin, C. M.
Lacke, C. L.
Land, J. F.
Lane, L. R.
Lange, R. D.
Langheim, W. E.
Lantis, L. R.
Lantis, Sharon D. H.
Larson, F. C.
Leclereq, Touissaint
Ledbetter, M. K.
Lemmer, K. E.
Lewis, W. C.
Liebl, E. R.
Lindblade, J. A.
Linden, R. E.
Lindgren, Richard
Link, R. W.
Lobeck, C. C.
Logan, Richard
Longley, B. J.
Lubar, H. S.
Lubing, H. N.
Lucas, A. M.
Lucas, G. L.
Lucia, G. E., Jr.
Luetke, W. V.
Lulloff, R. S.
Lyons, W. H.
Mackman, Sanford
Madsen, P. O.
Madsen, R. E.
Mahaffey, H. W.
Mahler, J. H.
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Suechting, R. L.
Talbot, A. E
Talens, A. C.
Varberg, W. R.
Viste, K. M., Jr.
Zimmerman, D. E.

Neillsville:
Capati, A. C.
Capati, N. R.
Comstock Elizabeth
Gungor, B. O.
Manz, K. F.
Ozturk, C. H.
Rosekrans, M. C.
Thompson, T. N., Jr.

Nekoosa:
Pfeiffer, L. R.
Thompson J. E.

New Berlin:
Fishburn, C. W.
Gilbert, Francis
Gjud, A. M.
Komar, R. R.
Selle, F. S.

New Franken:
Looze, J. A.

New Glarus:
Marty, P. H.

New Holstein:
Engel, A. C.
Larme, F P
Vosmek, J F.

New Lisbon:
Parong T. M.
Weston, C. H.

New London:
Galang, L. L.
Monsted, J. W.
Schmallenberg, H. C.
Weber, J. W.

New Richmond:
Armstrong, J. H.
Cralg, J. L.
Davis, R. R
Drury, E. M.
Epley, O H
Melby, M. A.
Weisbrod, L. W.

Niagara:
Maginn, Richard J.
McCormack, E. A.

Norwalk:
Allen, J. S.

Oak Creek:
Jerofke, Alfred

Oconomowoc:
Brummitt, C. D.
Claude, J. L.
Epperson, D. P.
Frank, E. B.
Goral, T. J.
Hearn, R. F.
James, W. D.
Lameka, Peter
Lubitz, J. M.
Marden, P. M.
Matt, J. R.
Miller, G. D.
Otto, Owen
Pruscha, C. S.
Rogers, A. F.
Schroeder, T A.
Schuele, D. T.
Schumacher, B. J.
Theobald, P. B.
Weir, E. F.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, P. M.

Oconto:
Honish, John S.
Rogers, R. J.
Zantow, F. E.

Oconto Falls:
Culver, J. R.
Heinen, R. D.
Siefert, C. E
Strebe, K. L.
Theisen, J. K.

Omro:
Peck, D. D.
Schoenbechler, L. J.

Onalaska:
Boomer, R. B.

Oostburg:
Johnston, T. L.
Moir, J. M.

Oregon:
DuKerschein, F. M.
Johnson, E. S.
Kellogg, L. S.
Watts, A. D.

Orfordville:
McNair, E. R.

Osceola:
Inyart, J. R.
Simenstad, J. O.
Simenstad, L. O.

Oshkosh:
Apell, M. G.
Basiliere, J. L.
Becker, D. B., Jr.
Behnke, C. H.
Bitter, R. H.
Bowerman, C. I
Buck, R. E.
Clark, W. E.
Crawford, W. A.
Cummings, E F.
Cunningham, T. E.
Danforth. H. J.
Deoras, M. P.
Downing, E. L.
Enrich. P. S.
Gordon, J. J.
Graber, L. D.
Graiewski, S. J.
Greenwood, Ben. S.
Greischar, Robert
Guenther, V. G.
Hahn, W. V.
Haines, M. C.
Hitselberger, J. F.
Hughes, J. B.
Hughes, R. C.
Hull, S. B.
Isom, R. G.
Kammholz, L. P.
Kivlin, T. M.
Koehler, A. G.
Kuhn, R. V.
Leibenson, S. J.
Leschke, John A.
Lyons, C. R.
Mathison, J. A.
McAndrew, J. B.
McKenzie, J. R.
Meli, J. V.
Minnihan, R. L.
Monday, Harvey
Neubecker, R D.
O'Connor, P. C.
Payne, J. C.
Petersik, J. T.
Ping, E. C
Plos, J. R.
Roberts, R. W.
Romberg, H. A.
Scheuermann, N. M.
Seay, M. J.
Simonson, M. J.
Steen, M. H.
Stilp, L. C.
Stone, L. H.
Wagner, R. F.
Wagner, W. A.
Weber, W. G.
Williams, E. B.
Wilson, E. B.
Winter, E. F.
Wolfgram, R. C
Wright, E. N.
Zmolek, E. J.

Osseo:
Garber, B. G.
Garber, R. D.
Leasum, R. N., Jr.

Oxford:
Baylon, R. R.
Wlejia, G. B.

Pardeeville:
Westcott, T. S.

Park Falls:
Enzinger, Josef
Eyvindsson, E. T
Leahy, J. D.
Murphy, J. L.

Peshtigo:
Barrette, Antoine

Pewaukee:
Visaya, M. C.

Phelps:
Wolcott, R. R.

Phillips:
Niebauer, W. E.

Plain:
Galarnyk, I. A.

Platteville:
Andrew, C. H.
Gurkow, H. J.
Moffett, J. L.
Nuland, S. J.
Steidinger C. L.
Stuessy, M. F.
Young, C. W.

Plum City:
Docter, C. W.
Docter, J. C.

Plymouth:
Alvarez, R. J.
Brickbauer, A. J.
Cruz, S. J.
Evers, R. H.
Gutowski, Franz
Steffan, L. J.
Weisse, H. A.

Portage:
Bronson, F. H.
Cooney, R. T.
Grose, C. D.
Henney, T. E.
Jones, W. W.
MacGregor, J. W.
Pavelsek, J. W.
Rueckert, R. R.
Saxe, J. J.
Taylor, S. F.
Taylor, W. A.
Tierney, E. F.
Villavicencio, C. A.
Zank, H. A. Binnie

Port Edwards:
Glenn, E. C.

Port Washington:
Bach, M. J
Barr, A. H.
Corcoran, W. A., Jr.
Henkle, R. F.
Kauth, C. P.
Savage, G. F.
Wallestad, P. W.
Walsh, John F.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Prairie du Chien:
Dessloch, E. M.
Epley, V. C.
Farrell, T. F.
Garrity, M. S.
Satter, O. E.
Wong, J. R.

Prairie du Sac:
Bishop, P. R.
Carlson, H. P.
Zauft, G. W.

Prescott:
Laney, H. J.

Princeton:
Mueller, G. G.

Pulaski:
Rustia, R. M.
Shippy, V. J.

Racine:
Ageloff, Harry
Albino, J. M.
Alexander, A. C.
Altenberg, B. M.
Bacon, G. A.
Barina, H. J.
Baumblatt, D. P.
Baylon, V. A.
Bein, Robert
Bennett, W. H.
Bliwas, Arnold
Brewer, G. W.
Brooks, J. C.
Bruton, J. T.
Buckley, W. E.
Burch, V. J.
Burke, Donald
Christenson, C. W.
Coffey, B. T.
Cohill, D. F.
Covell, K. W.
Cushman, S. M., Jr.
Currie, R. E
DeGroot, H. E.
Dorman, T. W.
Englander, S. M.
Faber, S. J.
Fazen, L. E., Jr.
Ferrazzano, G. P.
Floch, L. J.
Fogle, R. J.
Foreman, J. W.
Fralich, J. C.
Gardetto, P. A.
Geenen, J. E.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Graf, A. E.
Grant, A. B.
Grinney, June L.
Grinney, L. R.
Hammes, J. R.
Harris, W. C.
Henken, W. F.
Herrmann, A. A.
Hilker, H. C.
Jacobsen, A. J.
Jamieson, J. G.
Johnson, P. S.
Kaarakka, O. F.
Keland, H. B.
Khoja, Sherali
Kim, B. H.
Kim, D. K.
Kolmeier, K. H
Konnak, Wm. F.
Kontra, D. J.
Kreul, R. W.
Kreul, W. R
Lauerman, E. P.
Lehner, R. H.
Leitschuh, R. B.
Little, W. J., Jr.
MacVicar, E. L., Jr.
Maden, W. J.
Martinez, M. E.
Mayer, R. J.
McHale, J. A.
Miller, H. C.
Miller, P. L.
Miller, V. M.
Miller, W. C.
Minton, Richard
Nelson, M. W.
Nickelsen, J. R.
Oberdorfer, C. E.
Olson, E. S.
Ortwein, R. K.
Parker, M. G.
Patton, C. H.
Petersen, J. J. G.
Pinkus, W. H.
Pope, F. W.
Postorino, J. D
Rafiullah, Mahammed
Reyes, J. E., Jr.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Scheible, F. J.
Scheller, R. F.
Schenkenberg, Grace E.
Schleper, A. J.
Schroeder, H. T.
Schuster, Myron
Shack, J. B.
Short, H. W.
Siegert, R. F.
Simonsen, T. E.
Skow, G. D.
Skupniewicz, R. E.
Smith, L. W.
Smollen, W. J.
Steffen, Elizabeth A.
Stika, E. A.
Storey, J D.
Tomkiewicz, R. E.
Tsuchina, Goro
Veranth, J. J.
Villaflor, J. T.
Wilczynski, J. R.
Williamson, W. H.
Yasatan, N. H.

Randolph:
Horvath, D. C.

Random Lake:
Russell, J. A.

Reedsburg:
Booher, J. A.
Hanko, J. E.
Knight, Robert G.
Pawlisch, O. V.
Rouse, J. J.
Simeon, R. G.
Stadel, E. V.
Vergara, V. G.

Rhinelander:
Brown, J. F.
Bump, W. S.
Cline, Frances A.
Eggman, L. D.
Haug, Thomas M.
Kief, J. J.
Kim, H. Z. T.
Litton, E. W.
Litton, M. A.
Morris, W. G.
Nevin, Ismail Nik
Osborne, R. R.
Pratt, G. F.
Rosemeyer, O. G.
Schiek, I. E, Jr.
Simmons, W. K.
Thuerer, G. R.
Wright, Marvin

Rice Lake:
Cotts, L. R.
Eidsmoe, N. A.
Gillespie, M. E.
Henningsen, John
Hoyer, J. K.
Kristensen, L. A.
Kundel, R. R.
Maser, J. F.
Rydell, O. E.
Rydell, W. B.

Richfield:
Zintek, A. R.

Richland Center:
Edwards, R. W.
Glise, Roy C., Jr.
Housner, R. E.
Kelertas, J. H.
Meyer, K. H.
Parke, George, Jr.
Pippin, L. M.
Spear, Jack
Taft, D. J
Tischer, E. P.
Tydrich, J. J.

Rio:
Ferrer, M. M.

Ripon:
Bachus, A. C.
Johnson, J. M
Kilbourn, B. C.
Pelton, R. S.
Schuler, W. H.

River Falls:
Beix, J. R.
Dohnalek, D. W.
Grassl, F. O.
Hammer, R. M.
Haskins, P. S.
Palmquist, J. C.
Witt, D. L.

Rosholt:
Benn, V. A.

St. Croix Falls:
Ericksen, D. M.
Lagus A. T.
Nelson, L. K.
Olson, L. L.
Peterson, E. H
Riegel, F. B.
Riegel, J. A.
Wegner, M. E.

St. Francis:
Strube, R. H.

St. Nazianz:
Foley, M. E.

Sauk City:
Walsh, T. W.

Schofield:
Kuhn, J. M. R.
Nowinski, D. M.

Seymour:
Elliott, R. S.
Groendahl, R. C.
Hittner, V. J.
Leh, P. S. S.

Shawano:
Albright, J. J.
Arvold, D. S.
Bergmann, F. T.
Cantwell, A. A., Jr.
Cantwell, R. C.
Coan, W. A.
Hart, J. D.
Jeffries, Donald A.
Kurtz, C. G.
Logemann, R. L.
Petty, R. D.
Schulz, D. W.
Sebesta, A. J.
Wessels, D. H.

Sheboygan:
Ashby, A. O.
Bassewitz, P. P.
Batzner, D. J.
Bringe, J. W.
Cinelis, Ann A.
Dick, H. J.
Eckardt, B. F.
Gore, D. R.
Graf, C. A.
Gruenewald, Ludwig
Heinz, H. N.
Hidde, F. G.
Hildebrand, J. F.
Holmstrom, R. D.
Hoon, J. R.
Houfek, E. E.
Huibregtse, W. G.
Jaeck, J. L.
Jochimsen, E. H.
Johnson, R. C.
Jumes, M. G.
Keller, R. A.
Kovacic, J. F.
Kuplic, J. B.
Malewiski, L. J.
Marsho, B. S
Mason, P. B
McRoberts, J. W.
Michael, J. D
Mockert, Thomas
Moir, W. W.
Mueller, H. A.
Munoz, R. A.
Nause, F. P.
O'Donnell, S. P.
Pauly, L. F.
Pauly, R. C.
Pointer, R. W.
Quinn, G. A.
Rammer, M. A., Jr.
Reinemann, J. M.
Schott, E. G.
Schroeder, I. L.
Sciarra, P. A
Senty, R. M.
Simonson, L. M.
Simpson, R. M.
Stewart, O. K
Tasche, L. W.
Tompsett, A. C., Jr
Van Driest, J. J.
Weber, C. J.
Windsor, R. B.
Winsauer, H. J.
Wood, R. A.

Sheboygan Falls:
Hansen, H. J.
Weygandt, J. L.

Shell Lake:
Flogstad, D. L.
Matson, K. L.
Moen, D. V.
Welter, D. J.

Shorewood:
Vlazny, F. J.

Silver Lake:
De Witt, C. A.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Adali, I. S.
Crigler, R. R.
Grimm, J. J.
McFadden, Wayne
Murphy, G. V.
Schwartz, H. M.
Scerpella, J. R.
Spencer, G. N.
Theisen, C. E.
Turgai, Valerio

Sparta:
Albrecht, P. G.
Beebe, D. C.
Brown, J. D.
Buan, R. R.
Harris, A. J.
Lukasek, E. O.
Williams, H. H., Jr.

Spooner:
Goetsch, F. H.
Matzke, R. W.
Olson, L. J.

Spring Green:
Kempthorne, G. C.

Spring Valley:
Avestruz, A. P.
Avestruz, N. L.
Meyer, R. J.

Stanley:
La Breche, J. J.
Mathwig, R. J.
Sallis, D. A.

Stevens Point:
Anderson, G. H.
Anderson, H. P.
Benn, H. P.
Bickford, R. H.
Bosworth, W. C.
Eckberg, R. A.
Erickson, J. R.
Gehin, F. E.
Gramowski, W. A.
Hacker, P. K.
Iber, F. C.
Johnson, D. D.
Kennedy, J. T.
Kessler, R. A.
Klasinski, C. A.
Kohn, A. M.
May, E. G.
Milano, Angelo
Miller, J. D.
Miller, S. R.
O'Malley, T. P.
Pringle, D. L.
Reichardt, F. W.
Rice, M. G.
Rifleman, R. H.
Riordan, J. F.
Schierl, A. G.
Sciarrone, Francesco
Sevenich, J. R.
Sheehan, W. C.
Slater, R. H.
Sowka, A. J.
Sowka, P. N.

Stockbridge:
Knauf, J. A.

Stoddard:

Stone Lake:
Marlewski, C. R.
McNamara, T. B.

Stoughton:
Hermunstad, O. A.
Nelson, D. L.
Nordholm, V. W.
Peterson, R. K.
Schammel, F. M.
Schoenbeck, P. J.
Schoenbeck, R. F.

Stratford:
Kroeplin, F. C.

Sturgeon Bay:
Beck, J. G.
Beck, J. J.
Brook, J. J., Jr.
Evenson, R. G.
Grota, H. D.
Hobson, W. S.
Sheets, W. G.
Wagener, N. R.

Sun Prairie:
Behrend, J. F.
Green, R. E.
Nelson, E. J.
Rozum, L. T.
Russell, W. T.
Schutz, W. J.
Syty, Joseph

Superior:
Anderson, R. T.
Doyle, T. J.
Finn, Milton
Fruehauf, R. P.
Giesen, Conrad W.
Knights, J. A.
Krahl, Enzo
Lavine, I. H.
Lavine, M. M.
Mann, Robert
Mataczynski, R. R.
McGinnis, J. P.
Picard, C. J
Riabov, S. N
Rosin, L. R.
Scott, C. M.
Sellers, R. L.
Sincock, H. A.
Stack, E. G., Jr.
Thompson, R. T
Vergamini, J. C.

Theresa:
Langenfeld, G. P.

Thiensville:
Elbe, T. D.
Finger, W. A.
Herman, Murray
Klm, K. S.
Levy, E. S.
Ramin, J. E

Thorp:
Connolly, James

Tigerton:
Heise, L. F.

Tomah:
Kozarek, C. E.
Landmann, G. A., Jr.
Mansell, F. T.
Mubarak, J. S.
Ryan, C. J.

Tomahawk:
Bugarin, N. L.
Francisco, Orlando
Henderson, R. J.

Turtle Lake:
Halberg, A. C.

Twin Lakes:
Najafzodeh, Moktar

Two Rivers:
Kaner, S. L.
Kuljis, D. A.
Martin, R. E.
Mir A. A.
Myers, R. E.
Weld, S. L.
Zlatnik, A. P.
Zlatnik, P. A.

Union Grove:
Haedike, W. D.
Lawrence, P. J.
Lu, A. T.

Valders:
Thranow, J. A., Jr.

Verona:
Hirschler, C. W.
Pellett, J. R.

Viroqua:
Ender, C. A.
Gulbrandsen, L. F.
Kuehn, A. E.
Oppert, H. E.
Starr, R. A.
Vig, D. E.
Vig, De Verne W.
Vig, E. N.

Walworth:
Bruhn, I. J.
Coon, W. W.
Hansen, D. R.
Sapida, A. C.

Washburn:
Larson, H. H.
Olejnik, Waclaw
Telford, J. G.

Waterford:
Bardenwerper, H. W.
Botka-Wunder, G. M.
Dietz, R. J.

Waterloo:
Diancin, R. C.
Garman, J. S.

Watertown:
Baldwin, R. C.
Becker, J. H.
Burzynski, E. E.
Dixit, A. M.
Miller, E. A.
Nowack, L. W
Quanbeck, D. T.
Reed, W. H.
Schuh, E. P.

Waukesha:
Akture, M. A.
Alston, J. A.
Baker, J. B.
Barber, J. L.
Bartl, J. R.
Bartos, J. A.

Bartos, R. E.
Belson, T. P.
Bemman, K. C.
Bischel, J. R.
Bolger, James V., Jr.
Breyer, J. T.
Brown, W. E.
Buerger, E. J.
Buhl, J. L.
Bunke, J. W.
Burch, R. N.
Campbell, P. E.
Carnesale, P. G.
Carroll, P. E.
Church, Ruth E.
Clothier, W. J. K., Jr.
Darling, R. J.
Davies, E. B.
Davies, Gwilym
Desch, C. A.
Dugan, T. E.
Englund, S. A.
Feulner, R. C.
Flickinger, R. R.
Frantz, R. G.
Froeschle, R. P.
Fruchtman, M. Z.
Gallo, G. L.
Gantz, H. A.
Glazier, E. H.
Guy, J. R.
Harris, J. A.
Herman, L. H.
Hillan, D. D.
Holzgrafe, R. E.
Kascht, R. L.
Konetzki, W. H.
Kritter, A. E.
Leenhouts, K. C.
McCormick, G. L.
McCormick, M. R.
McDonell, T. H.
Mehr, M. P.
Merkow, William
Miller, O. E.
Monk, R. S.
Motzel, A. J., Jr.
Nolan, J. L., Jr.
Peterson, J. A.
Promer, J. E.
Rasmussen, R. J.
Richter, A. M.
Schmidt, C. W.
Schulz, E. G.
Small, J. T.
Smirl, W. G.
Smith, W. D.
Sweed, Aaron
Sydow, H. F.
Thompson, F. A.
Thorgersen, T. M.
Underberg, J. T.
Werra, B. J.
Wood, C. A.
Zietlow, F. G.

Waunakee:
Marquis, W. R.

Waupaca:
Boudry, M. O.
Haman, K. L.
Nelson, W. L.
Salan, J. R.
Salan, Sam
Steiner, J. H.

Waupun:
Chapman, M. J.
Hebenstreit, A. J.
Nemeth, Charles
Petters, W. J.
Schrank, L. W.
Schrank, R. E.
Wagner, W. A.

Wausau:
Andrews, G. R.
Aughenbaugh, D. K.
Ayengar, Shanta
Bachhuber, G. J.
Bachhuber, H. M.
Backer, G. L.
Backer, W. D.
Balliet, C. M.
Bartholomew, R. D.
Becker, W. T.
Brick, E. B.
Brister, G. H.
Brodhead, R. H.
Buechel, R. L.
Burr, Thurl C., Jr.
Cadwell, R. E.
Christensen, H. W.
Cravens, J. G.
Day, K. L.
Dyson, B. C.
Fechtner, H. H.
Flannery, J. V.
Flannery, J. V., III
Foerster, J. M.
Freeman, D. J.
Freeman, J. M.
Gargas, B. L.
Grauer, C. G.
Gulyn, A. B.
Gulyn, B. E.
Hammes, G. R.
Han, P. Z. Y.
Hattenhauer, J. M.
Hoessel, A. W.
Holmes, G. W.
Johnson, F. C.
Jones, M. L.
Kelley, O. R.
Knutson, K. R.
Kordiyak, George
Kramer, J. D.
Kranen, Donk H.
Krueger, L. A.
Larsen, R. B.
Leggett, R. D.
Locher, W. G.
MacCarthy, C. F.
Mallery, O. T.
Martens, J. H.
McCandless, E. E.
Miller, T. O.
Miller, W. C.
Mirhoseini, Mahmood
Mollnaro, A. J.
Muehlenbeck, E. C.
Norton, W. I.
Peterson, T. H.
Prehn, F. C.
Rossman, L. J.
Rudy, W. B.
Schroeder, G. H.
Schroth, G. J.
Shannon, R. C.
Smith, B. K.
Stahmer, A. H.
Stahmer, K. H.
Starkey, T. A.
Struthers, J. L.
Uecker, R. L.
Western, D. W.
Williamson, L. M.
Yoran, C. M.

Wausaukee:
Lee, A. M.

Wautoma:
Darby, R. C.
Meilicke, C. A.
Slattery, F. G.
Thompson, J. R.

Wauwatosa:
Arneth, J. J.
Baker, W. V.
Banker, V. P.
Bares, G. C.
Baumann, A. J.
Beck, K. H.
Beffel, J. M., Jr.
Biedlingmaier, G. J.
Birge, E. A.
Blatnik, D. S.
Bonan, J. D.
Boyle, R. W.
Brown, R. C.
Buggy, W. J.
Calvy, D. W.
Cordes, V. J.
Curtis, William C.
Dall, G. A.
Daniels, E. R.
Deardorff, W. L.
Dettmann, N. F.
Engstrom, W. W.
Falecki, J. W.
Feierstein, W. E.
Fifrick, L. L.
Filmanowicz, Edward
Flanary, J. R.
Hanauer, M. M.
Hansen, S. V.
Hensley, G. T.
Hofmeister, F. J.
Jenk, L. F.
Josephson, Morton
Junkerman, C. L.
Kegel, T. A.
Kehlnhofer, F. H.
Kloehm, R. A.
Liefert, R. A.
Mariens, W. E.
McClelland, G. B.
McDermott, J. F.
McGrath, D. J.
Nocella, R. A.
Nordin, P. F.
O'Connell, James R.
Olinger, J. K.
Osgood, C. W.
Pendergast, T. J.
Pier, W. J., Jr.
Pilliod, J. V.
Reed, A. E., Jr.
Reik, R. P.
Ricciardi, I. J.
Schmidt, E. J.
Schmidt, J. R.
Schoeneman, R. H.
Schulte, W. J.
Schulz, Irwin
Schwartz, W. F.
Seifert, K. A.
Stuhler, J. D.
Sweet, D. F.
Tulecke, J. B.
Twelmeyer, H. F.
Urban, F. H.
Urlakis, K. J.
Verch, L. H.
Vondrak, B. F.
Wendt, W. P.
Wilson, J. W.
Wright, H. H.
Winters, K. J.
Worm, G. J.
Zellmer, R. E.
Ziolkowski, J. S.

West Allis:
Bahr, R. D.
Clifford, R. M.
Collins, E. G.
Couch, J. R.
Cramer, R. P.
Frederick, R. H.
Fulton, J. W.
Heinan, F. C.
Hermann, W. C.
Jochimsen, M. A.
Kuzdas, J. R.
Millar, I. M.
Miller, L. E.
Miller, M. D.
Miner, D. L.
Nellen, J. R.
Rumhoff, Gordon
Savitt, A. J.
Staves, N. P.
Stern, C. S.
Stern, L. S.
Stern, R. S.
Wenders, J. A.
Wilkinson, E. D.
Zawodny, S. E.
Zenz, Carl
Ziebert, A. P.
Zimmer, J. F.
Zimmer, J. J.

West Bend:
Baumgartner, J. F.
Bush, F. I.
Frankow, R. O.
Geiger, C. S., Jr.
Gibson, R. D.
Grundahl, A. T.
Morbeck, F. E.
Nielsen, W. A.
Scheunemann, W. E.
Sorensen, R. F.
Vegafria, J. O.

Westby:
Bland, P. T.

West De Pere:
Gutheil, D. A.
Keiser, O. S.
Lenz, R. B.

West Salem:
Engel, C. H.
Gersch, G. P.
Gundersen, S. B.
Swarthout, Edyth C.

Westfield:
Demke, R. L.

Weyauwega:
Maasch, L. P.

Whitefish Bay:
Adlam, R. T.
Bernas, A. A.
Brady, J. J.
Lang, J. L.
Lang, G. E.
Samter, T. G.
Zabors, T. E.

Whitehall:
Cacahuela, T. D.
Simons, N. S.

Whitewater:
Ambrose, S. H.
Yao, F. C.

Wild Rose:
Hong, Roy
Kjentvet, R. A.
Ludwig, E. P.
Wichmann, R. D.

Williams Bay:
Wiswell, C. Y.

Wind Lake:
Cook, H. E.

Winnebago:
Baker, R. K.
Bobowski, C. D.
Gammell, G. H.
Haque, I. U.
Kubiak, Mary K.
Loftus, E. R.
Tseng, Kwo-Hwa

Winneconne:
Anderson, G. R.
Driscoll, L. J.
McDonald, D. H.

Wisconsin Dells:
Conley, H. L.
Gissal, F. W.

Wisconsin Rapids:
Allen, William
Arendt, C. J.
Arendt, N. W.
Debus, E. E.
Dietsche, W. G. W.
Garrison, R. E.
Hulme, A. W.
Johnson, R. L.
Park, J. K.
Pomainville, H. G.
Pomainville, L. C.
Schaller, J. W.
Starr, C. H.
Wittchow, A. W.
Wood, C. F.

Withee:
Johnson, J. W.

Wonewoc:
Baker, H. P.

Wood:
Dessel, B. H.
Dorn, R. G.
Flynn, R. T.
Friedberg, H. D.
Heckman, M. G.
Henschel, E. O.
Kampine, J. P.
Kory, R. C.
Lehman, R. H.
Leitschuh, T. H.
Meade, R. C.
Pecina, Ivo
Remus, C. J.
Ruetz, P. P.
Seno, E. C.
Theil, G. B.
Unger, C. F.
Unger, J. D.
Wang, R. I. H.

Woodruff:
Brown, D. H.
Farrington, J. D.
Hendrickson, A. O.
Hendrickson, William
Hiatt, W. R.

Woodville:
Helser, P. Arthur

Wrightstown:
Vande Loo, F. B.

Out-Of-State Members

Afrasiabi, Cyrus------Isfahan, Iran
Allen, Maury------Englewood, Colo.
Alt T. H.--------Minnetonka, Minn.
Anderson, E. M.------Sun City, Ariz.
Anderson, J L.-----Bellevue, Nebr.
Angevine, D. M.--Washington, D. C.
Anszman, P. E.---------Miami, Fla.
Babbitz, A. L.------Hallandale, Fla.
Banyai, Andrew L.
----------St. Petersburg, Fla.
Barbo, Dorothy M.----Punjab, India
Baum, E. L.----------Naples, Fla.
Beffel, J. M.-------San Diego, Calif.
Beglinger, H. F.--Palm Springs, Calif.
Belza, Janusz--Pebble Beach, Calif.
Bernards, W. C.------Portland, Ore.
Bornstein, S. L.----Hallandale, Fla.
Brennan, J. T.--------Augusta, Ga.
Brightbill, F. S.----Gainesville, Fla.
Broderick, C. F.-----Sun City, Ariz.
Brooks, J. R.
---------Glenwood Springs, Colo.
Bryan, A. R.-------Rochester, N. Y.
Buckley, C. H.--------Sarasota, Fla.
Burg, R J.----Randolph AFB, Tex.
Capozzi, Angelo-----Tiburon, Calif.
Chaudhary, M. A.
---------Kansas City, Kans.
Chisholm, T. P.
----------Ft. Sam Houston, Tex.
Clark, D. M.----------Rockton, Ill.
Clarke. G. S.----Bloomington, Minn.
Connors, C. B.-------Annapolis, Md.
Cooper, G. N.------Providence, R. I.
Crumpacker, Margaret
----------Kow Loon, Hong Kong
Curran, W. P.--Boynton Beach, Fla.
DiRiamondo, J. G.
----------New Hyde Park, N. Y.
Doege, P. F.----------Tucson, Ariz.
Doyle, R. F.----------Rockford, Ill.
Driessel, R. H.----Piscataway, N. J.
Drew, F. E.----Lighthouse Pt., Fla.
Duer, G. R.-----Winter Haven, Fla.
Edelman, E. R.--Los Angeles, Calif.
Enders, L. J.
----------Colorado Springs, Colo.
Esener, Ismail----------Rome, Ga.
Feierabne, Theodore
---------Ludhiana, Punjab, India
Fernando, O. U.---Southfield, Mich.
Flaherty, G. S.------Sun City, Ariz.
Frawley, D. D.------Sun City, Ariz.
Gemmill, W. D.---------Toledo, Ohio
Geretti, R. J.---------Phoenix, Ariz.
Gilmar, R. L.------Indianapolis, Ind.
Gloss, A. J.----------Bensenville, Ill.
Gottlieb, A. M.-----Palo Alto, Calif.
Graham, A. P.----------Largo, Fla.
Grant, L. C.---------Spokane, Wash.
Hardman, D. R.----Pittsburgh, Pa.
Hargarten, L. W.----Oakland, Calif.
Harris, G. W.---Ft. McClellan, Ala.
Harris, R. C.
----Wright Patterson AFB, Ohio
Heath, Hunter, III
----------Silver Spring, Md.
Hededus, A. A.--------Hemet, Calif.
Heeb, H. J.
--------Howey in the Hills, Fla.
Heil, J. U.----------Poway, Calif.
Helm, F. C ---FPO New York, N. Y.
Herzog, J. V.--------Sun City, Ariz.
Holder, J. B.-------Allison Park, Pa.
Holzman, B. R.
-------APO San Francisco, Calif.
Horning, J. S.
---Quito, Ecuador, South America
Hunter, A. L.----Green Valley, Ariz.
Huth, E. P.---------Englewood, Fla.
Ihle, C. V.
-------APO San Francisco, Calif.
Janis, Martin-----San Rafael, Calif.
Jensen, Alfhild--------Puli, Taiwan
Joseph, L. G.-------Camarillo, Calif.
Kay, E. M.------Palm Desert, Calif.
Kelly, G. F.----------Berkeley, Calif.
Killins, W. A.---------Carmel, Calif.
Kincaid, C. K.----------Mobile, Ala.
Kirkham, B. C.---New Orleans, La.
Kinsey, J. L.------San Diego, Calif.
Klutzow, F. W.---Chevy Chase, Md.
Kraft, J. W.----------Reno, Nev.
Kratchovil, C. H.----Portage, Mich.
Krautkramer, Ronald
----------Wichita Falls, Tex.
Kurtz, E. C.-----Foster City, Calif.
Lass, T. E.------Fayetteville, N. C.
Larson, A. N.------Cincinnati, Ohio
Levis, E. H.----------Warner, N. H.
Lindner, Anton-----Brooklyn, N. Y.
Lipman, W. H.------La Jolla, Calif.
Lloyd, B. E.
-------Ft. Dauphine, Madagascar
Love, R. G.----------Lansing, Ohio
Maguire, D. W.-----Great Lakes, Ill.
Manier, J. W.---Minnetonka, Minn.
McCabe, John----------Austin, Tex.
McCabe, L. B.---Fort Jackson, S. C.
McLaughlin, J. T.
---------Huntington Beach, Calif.
Messenger, M. A.----St. Paul, Minn.
Meyer, G. A.-------Galveston, Tex.
Miller, M. H.-----Vancouver, Canada
Millington, P. E.
----------Horseshoe Bend, Ariz.
Morten, S. A.------Beirut, Lebanon
Mourad, William--Port Huron, Mich.
Murley, H. D.-----Scottsdale, Ariz.
Newman, C. R.------Prescott, Ariz.
O'Donnell, M. J.--Wadsworth, Kans.
Olsen, V. B.----------Wheaton, Ill.
Olson, A. P.-------Phoenixville, Pa.
Olson, M. H.--------Galveston, Tex.
Otterson, W. N.
----------Ft. Sam Houston, Tex.
Overgard, A. W.--Farmington, Minn
Owen, J. D.-------Cave Creek, Ariz.
Pansch, D. J.
----------Wirtsmith AFB, Mich.
Parnell, Francis J.
----------Greenbrae, Calif.
Pedraza, Pablo
---------Ft. Leonard Wood, Mo.
Pember, A. H.----Lake Wales, Fla.
Pettera, R. L.
----------APO New York, N. Y.
Pfefferkorn, E. B.-Culver City, Calif.
Pitlyk, P. J.-----Burlingame, Calif.
Plotkin, Martin--Maxwell AFB, Ala.
Pratt, Mary----------Boston, Mass.
Pugh, C. J.------Punta Gorda, Fla.
Quade, R. H.---------Sedona, Ariz.
Randall, M. W.
---------Colorado Springs, Colo.
Reslock, C. P.-------Tonopah, Nev.
River, G. L.-----Youngstown, Ohio
Roisum, B. H.------Salisbury, N. C.
Rosmann, H. K.------Winnetka, Ill.
Sanderson, R. J.--Hot Springs, Ark.
Santilli, R. J.------Ft. Belvoir, Va.
Sazama, F. B.-----Scottsdale, Ariz.
Schatz, W. R.----------Ceres, Calif.
Schmidt, C. H.
----------Barksdale AFB, La.
Schmidt, J. P.-------Springfield, Ill.
Schoenwetter, C. D.
----------Washington, D. C.
Shambaugh, G. E., III--Chicago, Ill.
Sholtes, C. A.----Port Richey, Fla.
Smith, P. H.-------Falmouth, Mass.
Spence, C. H.------Warminster, Pa.
Stinson, H. K.--Madang, New Guinea
Storms, W. W.----Ft. Carson, Colo.
Stube, R. W.----------Naples, Fla.
Tasche, J. A.----------Sarasota, Fla.
Thranow, J. A.--------La Belle, Fla.
Valaske, M. J.-------Bethesda, Md.
Van Riper, H. E.
----------South Berry, Conn.
Wagner, P. C.---Ft. McClellan, Ala.
Werba, Daniel-------Phoenix, Ariz.
Werra, R. J.----------Ukiah, Calif.
Weston, E. L.---------Denver, Colo.
Wheeler, R. M.
----------Fort Lauderdale, Fla.
Wirka, H. W., Jr.
----------South Pasadena, Calif.
Zizic, T. M.----------Baltimore, Md.

Honorary Members

Bradley, H. C., Ph.D.
----------Berkeley, Calif.
Clark, P. F., Ph.D. ---Madison, Wis.
Hardgrove, Maurice
----------Milwaukee, Wis.
Hardman, H. F. ---Milwaukee, Wis.
Hunter, A. L. ---Green Valley, Ariz.
McCabe, John ---------Austin, Tex.
Mortensen, O. A. ----Madison, Wis.
Morton, Silvanus A.
----------Beirut, Lebanon
Pusey, W. A., Ph.D. ---Chicago, Ill.
Quick, A. J. ------Milwaukee, Wis.
Shideman, F. E. -Minneapolis, Minn.

Scientific Fellow

Berman, A. L., Ph.D. ----------Madison

Life Members

*Adamkiewicz, J. J.-----Milwaukee
Anderson, N. P. --------La Crosse
Andrew, C. H. ---------Platteville
Baum, E. L. ----------Naples, Fla.
Boren, C. H. ----------Marinette
Buckley, W. E. ----------Racine
Busse, A. A. ----------Jefferson
Carlsson, E. S.----------La Crosse
Carter, H. M. ----------Madison
Comstock, Elizabeth ---Neillsville
Duer, G. R. ---Winter Haven, Fla.
Eck, G. E. ----------Lake Mills
Egan, W. J. ----------Milwaukee
Epley, O. H. -------New Richmond
Fitzgerald, R E. -------Milwaukee
Foerster, H. R.----------Milwaukee
Franklin, Isadore ------Milwaukee
*Freeman, J. M. ----------Wausau
Graner, L. H. ----------Coleman
Gundersen, Gunnar -----La Crosse
Heeb, H. J.
-----Howey in the Hills, Florida
Hoffmann, J. G. ---------Hartford
Hoffmann, L. A. ----Campbellsport
Hogan, John H. --------Fish Creek
Jones, M. L. ----------Wausau
Judge, T. A. ----------Milwaukee
Keland, H. B. ----------Racine
*King, J. M. ----------Milwaukee
Koch, H. C. ----------Berlin
Koch, M. J. ----------Milwaukee
Koehler, A. G. ----------Oshkosh
Leahy, J. D. ----------Park Falls
Leonard, C. W. ------Fond du Lac
*Lewis, Marian ---------Milwaukee
McGarty, M. A. ---------La Crosse
Merten, A. N. E. -------Milwaukee
Middleton, W. S. ---------Madison
Nadeau, E. G. ----------Green Bay
Newman, J. R. ----------Madison
Ovitz, E. G. ----------Laona
Pleyte, A. A. ----------Milwaukee
Pope, F. W. ----------Racine
Randall, M. W.
---------Colorado Springs, Colo.
*Riegel, J. A. ------St. Croix Falls
Rose, J. F. ----------Lena
Roth, W. C. ----------Racine
*Scholter, E. A. W. -----Milwaukee
Schwartz, A. B. ---------Milwaukee
Simons, N. S. ----------Whitehall
Sincock, H. A. ----------Superior
*Sisk, Ira R ----------Madison
Stiennon, O. A. ----------Madison
Taylor, W. A. ----------Portage
Tharinger, E. L. -------Milwaukee
Towne, W. H. ---------Hortonville
Waldschmidt, W. J. --Fond du Lac
Zank, H. A. ----------Portage

*Granted life membership in 1971.

Implied Consent

ANY PERSON OPERATING A MOTOR VEHICLE on the highways of the State of Wisconsin is deemed to have given consent to a test of his blood, breath, or urine to determine the alcohol content of his blood.

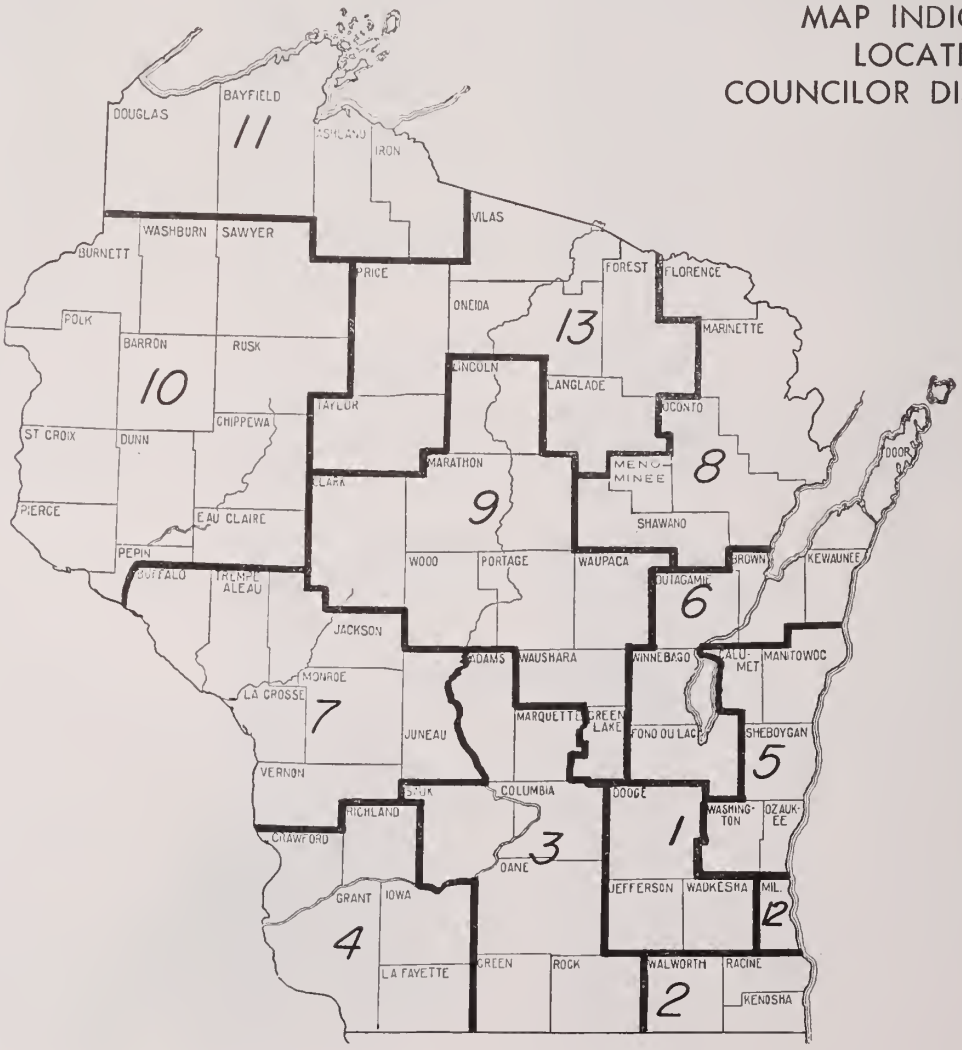
This law comes into operation only if the person is arrested and cited for driving under the influence of an intoxicant.

Refusal to submit to a test for blood alcohol under implied consent may lead to suspension of one's driver's license or a mandatory two-day imprisonment if convicted.

Under the law, only a physician or one acting under the direction of a physician may withdraw blood for the blood test, if used. The law provides immunity from liability, except for negligence, for persons drawing blood for implied consent testing.

The State Medical Society of Wisconsin has prepared guidelines for physicians in connection with their responsibilities under the implied consent law. These guidelines and a copy of the consent form may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701, or telephone 608/257-6781. (Single copies: 25¢ with order)

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



Officers and Councilors 1971-1972

State Medical Society of Wisconsin

OFFICERS OF THE SOCIETY

PRESIDENT (1971–1972) .....**G. A. Behnke, MD**
1015 West Wisconsin Ave., Kaukauna 54130

PRESIDENT-ELECT (1971–1972) .....**R. F. Purtell, MD**
758 N. 27th St., Milwaukee 53208

SECRETARY .....**E. R. Thayer**
330 East Lakeside St., Madison 53701

TREASURER (1971–1972) .....**F. L. Weston, MD**
166 Lakewood Blvd., Madison 53704

SPEAKER (1971–1973) .....**T. J. Nereim, MD**
P.O. Box 65, Mt. Horeb 53572

VICE-SPEAKER (1971–1972) .....**W. D. Hamlin, MD**
Mineral Point 53565

PAST PRESIDENT (1971–1972) ....**J. W. McRoberts, MD**
1011 North Eighth St., Sheboygan 53081

THE COUNCIL

E. J. Nordby, MD, Madison, Chairman

J. E. Dettmann, MD, Green Bay, Vice-chairman

COUNCILORS AND DISTRICTS*

First: Dodge, Jefferson, and Waukesha County Societies. **L. W. SCHRANK, MD** (1969–1972), 600 Fern St., Waupun 53963.

Second: Kenosha, Racine, and Walworth County Societies. **R. S. Galgano, MD** (1969–1972), 610 Walworth Ave., Delavan 53115.

Third: Dane, Columbia–Marquette–Adams, Green, Rock, and Sauk County Societies. **E. J. Nordby, MD** (1970–1973), 2704 Marshall Ct., Madison 53705; **M. F. Huth, MD (1971–1974)**, 203 Fourth St., Baraboo; **Gordon Davenport, Jr., MD** (1969–1972), 20 South Park St., Madison 53715.

Fourth: Crawford, Grant, Iowa, Lafayette, and Richland County Societies. **R. W. Edwards, MD** (1970–1973), 1313 W. Seminary St., Richland Center 53581.

Fifth: Calumet, Manitowoc, Sheboygan, Washington, and Ozaukee County Societies. **W. F. Smejkal, MD** (1970–1973), Manitowoc 54220.

Sixth: Brown. Door–Kewaunee, Fond du Lac, Outagamie, and Winnebago County Societies. **Howard Mauthe, MD** (1970–1973), 3802 DeNeveu Lane, Fond du Lac 54935; **J. E. Dettmann, MD** (1971–1974), 1751 Deckner Ave., Green Bay 53401.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo, and Vernon County Societies. **E. P. Rohde, MD** (1971–1974), Galesville 54630.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. **R. D. Heinen, MD** (1971–1974), 134 N. Main St., Oconto Falls 54154.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca, and Wood County Societies. **R. F. Lewis, MD** (1971–1974), 650 S. Central Ave., Marshfield 54449.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, and Rusk County Societies. **W. R. Manz, MD** (1971–1974), 204 East Grand Ave., Eau Claire 54701.

Eleventh: Ashland–Bayfield–Iron, and Douglas County Societies. **T. J. Doyle, MD** (1969–1972), 1507 Tower Ave., Superior 54880.

Twelfth: The Medical Society of Milwaukee County. **T. J. Foley, MD** (1969–1972), 3316 West Wisconsin Ave., Milwaukee 53208; **D. K. Schmidt, MD** (1970–1972), 330 W. Silver Spring Drive, Milwaukee 53217; **W. J. Egan, MD** (1970–1973), 525 East Wells St., Milwaukee 53202; **DeLore Williams, MD** (1971–1974), 8501 W. Lincoln Ave., West Allis 53227; **R. B. Pittelkow, MD** (1971–1974), 111 E. Wisconsin Ave., Milwaukee 53202; **P. G. LaBissoniere, MD** (1971–1973), 10425 W. North St., Wauwatosa 53226.

Thirteenth: Forest, Langlade, Oneida–Vilas, and Price–Taylor County Societies. **W. W. Meyer, MD** (1971–1974), 101 W. Gibson Ave., Medford 54451.

Past President McRoberts

President Behnke

Speaker Nereim

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

W. B. Hildebrand, MD (1972–1973), 59 Racine St., Menasha 54952.

R. E. Galasinski, MD (1972–1973), 3333 South 27th St. Milwaukee 53215.

J. M. Bell, MD (1971–1972), 516 Houston St., Marinette 54143

G. E. Collentine, Jr., MD (1971–1972), 2388 N. Lake Drive, Milwaukee 53211.

C. J. Picard, MD (1971–1972), 425 Twenty-first Ave., East, Superior 54880.

Alternates

W. T. Russell, MD (1972–1973), 114 Columbus St., Sun Prairie 53590.

H. F. Twelmeyer, MD (1972–1973), 2500 N. Mayfair Rd., Wauwatosa 53226.

E. M. Dessloch, MD (1971–1972), 421 S. Beaumont, Prairie du Chien 53821.

D. J. Carlson, MD (1971–1972), 2320 North Lake Dr., Milwaukee 53211.

H. J. Kief, MD (1971–1972), 505 East Division St., Fond du Lac 54935.

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* Map indicating location of councilor districts, page 66.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May. Dates in parentheses indicate beginning and expiration of term of office.

The Council of the State Medical Society of Wisconsin—November 18, 1971

AROUND THE TABLE CLOCKWISE: MDs L. W. Schrank, Waupun; T. J. Foley, Milwaukee; W. F. Smejkal, Manitowoc; W. W. Meyer, Medford; R. F. Lewis, Marshfield; W. J. Egan, Milwaukee; J. E. Dettmann, Green Bay (vice-chairman); D. K. Schmidt, Milwaukee; G. A. Behnke, Kaukauna (president); E. J. Nordby, Madison (chairman); R. F. Purtell, Milwaukee (president-elect); R. S. Galgano, Delavan; Gordon Davenport, Jr., Madison; W. R. Manz, Eau Claire; R. W. Edwards, Richland Center; R. D. Heinen, Oconto Falls; Howard Mauthe, Fond du Lac; DeLore Williams, West Allis; E. P. Rohde, Galesville; and T. J. Nereim, Madison (speaker). Councilors not present for picture are: MDs M. F. Huth, Baraboo; T. J. Doyle, Superior; R. B. Pittelkow, Milwaukee; and P. G. LaBissoniere, Wauwatosa; also J. W. McRoberts, MD, Sheboygan (past president). Others attending the meeting are seated at the left: George H. Handy, MD, Madison (state health officer); G. E. Collentine, Jr., MD, Milwaukee (AMA delegate); D. J. Carlson, MD, Milwaukee (AMA alternate delegate); W. T. Russell, Sun Prairie (alternate); H. J. Kief, Fond du Lac (alternate); H. F. Twelmeyer, Wauwatosa (alternate); and Raymond Headlee, Elm Grove (editorial director, *Wisconsin Medical Journal*).

Standing Committees—1971-1972

State Medical Society of Wisconsin

COMMITTEE ON CANCER

(Composed of a member from each Councilor District)

John K. Scott, MD
Chairman

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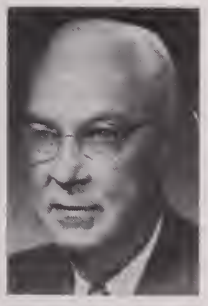

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Planning
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Commission on Safe Transportation
Commission on State Departments
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Regional Administration for Wisconsin is in District 5, with Chicago offices for both the Department of Labor and the Department of Health, Education, and Welfare.

For information about the Federal Occupational Health and Safety Standards, contact the Department of Labor:

Edward E. Estkowski, Administrator
Occupational Safety and Health Administration
300 South Wacker Drive, Room 1201
Chicago, Illinois 60606 (312) 353–4716

Area Office, Milwaukee, Wisconsin:
Robert Hanna, Director
Sheraton–Schroeder Hotel, Room 906–907
Milwaukee, Wisconsin 53203 (414) 271–7250

Information about record-keeping requirements under OSHA may be obtained from:
William E. Rice, Regional Director
Bureau of Labor Statistics
300 South Wacker Drive (312) 353–7235 for specific information
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Dodge	Rudolfo Molina 130 Warren St. Beaver Dam 53916	A. A. Ehrhardt 130 Warren St. Beaver Dam 53916
Door–Kewaunee	Weldon G. Sheets 108 S. 10th St. Sturgeon Bay 54235	Valentino Ancheta 375 Greenfield Ave. Algoma 54201
Douglas	Clarence M. Scott 318—21st Ave. East Superior 54880	Sviatoslav N. Riabov 312 E. 7th St. Superior 54880
Eau Claire–Dunn–Pepin	Harry E. Thimke 3746 Patton St. Eau Claire 54701	Verne A. Sperry 715 S. Barstow Eau Claire 54701
Fond du Lac	George F. Meisinger Route 3, Box 233C Fond du Lac 54935 *Treasurer:* E. Howard Theis 92 E. Division St. Fond du Lac 54935	Joseph C. Devine 105 Sheboygan Ave. Fond du Lac 54935
Forest	E. F. Castaldo Laona 54541	D. V. Moffet Crandon 54520
Grant	Glenn C. Hillery 235 N. Madison Lancaster 53813	H. W. Carey 257 Madison St. Lancaster 53813
Green	Eugene E. Eckstam 2118—20th Ave. Monroe 53566	M. M. Qureshi 1515 Tenth St. Monroe 53566
Green Lake–Waushara	J. C. Koch 209 E. Park Ave. Berlin 54923	Alonzo R. Gimenez 270 E. Marquette Berlin 54923
Iowa	E. J. Hohler 251 High St. Mineral Point 53565	H. P. Breier Montfort 53569
Jefferson	John S. Garman 111 W. Madison St. Waterloo 53594	David T. Quanbeck 1340 Linsey Place Watertown 53094
Juneau	Jack Strong Mauston 53948	Clayton Weston New Lisbon 53950
Kenosha	Louis Olsman 2108 63rd St. Kenosha 53140	G. S. Wadina 6530 Sheridan Rd. Kenosha 53140
La Crosse	Paul W. Phillips 212 S. 11th St. La Crosse 54601	Charles E. Link 212 S. 11th St. La Crosse 54601
Lafayette	R. E. Hunter Argyle 53504	D. F. Ruf 517 Park Place Darlington 53530
Langlade	Earl J. Roth 1111 Langlade Rd. Antigo 54409	Theodor Habel 1111 Langlade Rd. Antigo 54409
Lincoln	J. D. Millenbah 716 E. 2nd St. Merrill 54452	T. O. Vechinski Holy Cross Hospital Merrill 54452
Manitowoc	C. C. Kobelt 1017 Lincoln Blvd. Manitowoc 54220	J. R. Larsen 300 E. Reed St. Manitowoc 54220
Marathon	C. M. Balliet 400 Strollers Lane Wausau 54401	D. K. Aughenbaugh 400 Strollers Lane Wausau 54401
Marinette–Florence	John W. Boren, Jr. 1510 Main St. Marinette 54143	K. G. Pinegar 2500 Hall Ave. Marinette 54143
Milwaukee	David J. Carlson 2320 N. Lake Dr. Milwaukee 53211 *Exec. Dir.:* Mr. M. McManus 756 N. Milwaukee Milwaukee 53202	Barney B. Becker 2500 W. Lincoln Ave. Milwaukee 53215
Monroe	Jack D. Brown 202 South K. Sparta 54656	E. O. Lukasek 110 E. Franklin Sparta 54656
Oconto	J. K. Theisen 248 N. Main St. Oconto Falls 54150	J. R. Culver 150 N. Main St. Oconto Falls 54154
Oneida–Vilas	Henry S. Ashe P. O. Box 308 Minocqua 54548	L. D. Eggman 1020 Kabel Ave. Rhinelander 54501
Outagamie	W. H. Hale 420 E. Longview Dr. Appleton 54911	T. A. Ryan 424 E. Longview Dr. Appleton 54911
Ozaukee	Arnold H. Barr 118 E. Grand Ave. Port Washington 53074	Robert H. Dorr 650 Main Belgium 53004

County Medical Society	President	Secretary
Pierce–St. Croix	J. L. Craig 101 N. Main Ave. New Richmond 54017	Paul S. Haskins 409 Spruce River Falls 54022
Polk	D. J. Schroeder 127 Keller Ave. Amery 54001	William A. Fischer Frederic 54837
Portage	Francesco Sciarrone 900 Illinois Stevens Point 54481	J. R. Sevenich 1364 College Ave. Stevens Point 54481
Price–Taylor	J. L. Murphy 500 Birch St. Park Falls 54552	Josef Enzinger S Hwy 13 Park Falls 54552
Racine	R. E. Skupniewicz 5625 Washington Ave. Racine 53406 *Treasurer* Myron Schuster 717—15th St. Racine 53403	T. W. Dorman 3343 Douglas Ave. Racine 53402 *Exec. Secy.:* Mr. J. Wilber- shide P.O. Box 542 Racine 53401
Richland	E. Paul Tischer 1313 W. Seminary Richland Center 53581	L. M. Pippin 1313 W. Semi- nary Richland Center 53581
Rock	A. O. Tuftee 1146 Grant Beloit 53511	Donald Knepel 1344 Creston Park Dr. Janesville 53545
Rusk	J. E. Murphy 403 E. Miner Ave. Ladysmith 54848	Howard F. Pagel Ladysmith 54848
Sauk	Rudolfo G. Simeon 114 S. Park Reedsburg 53959	Victor G. Ver- gera, Jr. 442 2nd St. Reedsburg 53959

All officers above are M.D.'s unless labeled Mr.

County Medical Society	President	Secretary
Shawano	C. G. Kurtz 610 W. Green Bay St. Shawano 54166	A. J. Sebesta P.O. Box 311 Shawano 54166
Sheboygan	Herman J. Dick 2629 N. 7th St. Sheboygan 53081	Robert A. Keller 1011 N. Eighth St. Sheboygan 53081
Trempealeau–Jackson–Buffalo	Theresa D. Cachuela P.O. Box 507 Whitehall 54773	Eugene Krohn 610 W. Adams Black River Falls 54615
Vernon	P. T. Bland Westby 54667	DeVerne W. Vig 125 W. Jefferson Viroqua 54665
Walworth	J. B. Schrock, Jr. 100 S. Washington Elkhorn 53121	Irwin J. Bruhn Walworth 53184
Washington	V. V. Quandt P.O. Box 26 Hartford 53027	R. F. Sorensen P.O. Box 178 West Bend 53095
Waukesha	A. E. Kritter 217 Wisconsin Ave. Waukesha 53186 *Treasurer:* W. J. Clothier, Jr. 1149 Downing Dr. Waukesha 53186	K. J. Dempsey N88 W16951 Main St. Menomonee Falls 53051 *Exec. Secy.:* Mr. Robert Her- zog 2825 N. Mayfair Rd. Milwaukee 53222
Waupaca	Lloyd P. Maasch Box 805 Weyauwega 54983	John H. Steiner 208 E. Union St. Waupaca 54981
Winnebago	M. G. Apell 645 Doctors Ct. Oshkosh 54901	R. W. Roberts 400 Ceape Ave. Oshkosh 54901
Wood	Robert L. Johnson 452 Greenwood Dr. Wisconsin Rapids 54494	Francis Kruse, Jr. 630 S. Central Ave. Marshfield 54449

Compilation of Articles on: *The Best of Law and Medicine*

"The Best of Law and Medicine," a collection of articles appearing in *JAMA* during the period 1968–1970, has been compiled to help familiarize physicians with legal situations with which they may be confronted in their practice.

This collection deals with particular aspects of the impact of law upon the practice of medicine. Demand for reprints of the individual articles became so great that the AMA Committee on Medicolegal Problems suggested that a publication containing the most popular items be produced. The Legal Research Department of the AMA Law Division, which is responsible for content, selected the articles it felt would provide both interesting and useful reference sources for physicians, as well as others interested in this aspect of the law. This is the second printing, the first having covered *JAMA* articles for the period 1966–1968.

Medical liability, hospital liability, public policy and medicine, licensure and disciplinary actions, business problems, mental health, medical evidence, and other miscellaneous issues represent the eight major categories covered by the handbook. The 8½" x 11", 184-page paperback is *not* intended as a do-it-yourself law book for physicians, nor is it to be considered a substitute for personal legal advice from an attorney.

Residents in the U.S., U.S. Possessions, Canada and Mexico may secure a copy for $2.00. Medical students, hospital interns and residents in these areas may receive it for only $1.00. The price in all other countries is $2.50. Orders should be coded "OP-179" and directed to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

OFFICERS OF SCIENTIFIC SECTIONS OF THE STATE MEDICAL SOCIETY

SECTION ON ANESTHESIOLOGY

Chairman ..... Philip A. Hoffman, Madison
Secretary ..... Ruth A. Stoerker, Madison
Delegate ..... Jergen Barber, Waukesha
Alternate ..... John W. Temple, Milwaukee

SECTION ON DERMATOLOGY

Chairman ..... Robert R. Bauman, Monroe
Secretary ..... Hubert V. Moss, Madison
Delegate ..... Joel E. Taxman, Milwaukee
Alternate ..... Garrett A. Cooper, Madison

SECTION ON GENERAL PRACTICE

Chairman ..... Paul E. Wainscott, Menasha
Secretary ..... Nicholas F. Damiano, Hales Corners
Delegate ..... Norbert G. Bauch, Milwaukee
Alternate ..... Anthony J. Sanfelippo, Milwaukee

SECTION ON INTERNAL MEDICINE

Chairman ..... John M. Irvin, Monroe
Secretary ..... Robert C. Puestow, Manitowoc
Delegate ..... Robert C. Puestow, Manitowoc
Alternate ..... James A. Means, Milwaukee

SECTION ON MEDICAL FACULTIES

Delegate ..... Vacancy
Alternate ..... Vacancy

SECTION ON NEUROLOGY AND PSYCHIATRY

Chairman ..... William H. Heywood, Marshfield
Secretary ..... Vacancy
Delegate ..... Carroll W. Osgood, Wauwatosa
Alternate ..... Stanley Miezio, Madison

SECTION ON OBSTETRICS AND GYNECOLOGY

Chairman ..... Richard C. Brown, Eau Claire
Secretary ..... William J. O'Leary, Jr., La Crosse
Delegate ..... Robert P. Reik, Wauwatosa
Alternate ..... William E. Martens, Wauwatosa

SECTION ON OPHTHALMOLOGY

Chairman ..... Elmer E. Johnson, Madison
Secretary ..... George H. Anderson, Stevens Point
Delegate ..... George M. Sparks, Marshfield
Alternate ..... Herbert Giller, Milwaukee

SECTION ON ORTHOPEDICS

Chairman ..... Sion C. Rogers, Madison
Secretary ..... James M. Huffer, Madison
Delegate ..... Paul A. Jacobs, Milwaukee
Alternate ..... Peter B. Golden, Madison

SECTION ON OTOLARYNGOLOGY

Chairman ..... James H. Brandenburg, Madison
Secretary ..... Timothy J. Donovan, Madison
Delegate ..... Thomas W. Grossman, Milwaukee
Alternate ..... John M. Mills, Green Bay

SECTION ON PATHOLOGY

Chairman ..... Chesley P. Erwin, Elm Grove
Secretary ..... Roland C. Brown, Wauwatosa
Delegate ..... Edwin L. Bemis, Brookfield
Alternate ..... Herman J. Dick, Sheboygan

SECTION ON PEDIATRICS

Chairman ..... John R. Guy, Waukesha
Secretary ..... George G. Griese, Marshfield
Delegate ..... Richard L. Myers, Green Bay
Alternate ..... Victor J. Cordes, Wauwatosa

SECTION ON PHYSICAL MEDICINE AND REHABILITATION

Chairman ..... James F. McDermott, Wauwatosa
Secretary ..... Morris Mitz, Milwaukee
Delegate ..... Albert M. Cohen, Milwaukee
Alternate ..... Elmer C. Kocovsky, Elm Grove

SECTION ON PLASTIC SURGERY

Chairman ..... Gordon Davenport, Jr., Madison
Secretary ..... Vacancy
Delegate ..... Gordon Davenport, Jr., Madison
Alternate ..... Paul Natvig, Milwaukee

SECTION ON PUBLIC HEALTH

Chairman ..... Arthur L. Van Duser, Madison
Secretary ..... Josef Preizler, Madison
Delegate ..... Gertrude E. Howe, Madison
Alternate ..... George H. Handy, Madison

SECTION ON RADIOLOGY

Chairman ..... Leslie E. Jones, Fond du Lac
Secretary ..... Marvin L. Hinke, Milwaukee
Delegate ..... Vacancy
Alternate ..... Vacancy

SECTION ON SURGERY

Chairman ..... Ben R. Lawton, Marshfield
Secretary ..... Wilson Weisel, Milwaukee
Delegate ..... B. Jack Longley, Madison
Alternate ..... Robert G. Wochos, Green Bay

SECTION ON UROLOGY

Chairman ..... Timothy H. McDonnell, Waukesha
Secretary ..... John D. Silbar, Milwaukee
Delegate ..... John W. Kearns, Milwaukee
Alternate ..... Vacancy

All the above are MDs and members of the State Medical Society of Wisconsin.

ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, MD† 1930
Cornelius A. Harper, MD† 1930
John J. McGovern, MD† 1931
Louis M. Jermain, MD† 1931
Edward Evans, MD† 1931
Mina B. Glasier, MD† 1932
Arthur W. Rogers, MD† 1934
Rock Sleyster, MD† 1934
Olin West, MD† 1934
Edward A. Birge, PhD† 1935
Arthur J. Patek, MD† 1935
Joseph F. Smith, MD† 1937
Eben J. Carey, MD† 1938
William S. Middleton, MD 1938
Fred G. Johnson, MD† 1939
William D. Stovall, MD† 1940
Ludvig Hektoen, MD*† 1941
Stephen E. Gavin, MD† 1944
F. Gregory Connell, MD† 1947
E. R. Schmidt, MD† 1949
Armand J. Quick, MD 1950
F. A. Stratton, MD† 1951
Gunnar Gundersen, MD 1953
W. J. Meek, PhD† 1953
R. G. Arveson, MD† 1957
Edwin B. Fred, PhD 1958
Harry Beckman, MD 1959
Elizabeth Comstock, MD 1961
Harry Steenbock, PhD† 1963
Francis J. L. Blasingame, MD 1964
C. N. Neupert, MD† 1965
Spencer D. Beebe, MD† 1965
Frank L. Weston, MD** 1966
Robert E. Fitzgerald, MD** 1966
William B. Walsh, MD 1967
H. Kent Tenney, MD 1969
Charles H. Crownhart 1971

* Centennial Award. † Deceased.
** 125th Anniversary Award.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a non-physician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission) 1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library) 1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) 1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette 1965
Francis J. Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire 1966
Warren P. Knowles (Governor of the State of Wisconsin), Madison 1967
Leo C. Massopust (Scientific photographer, artist, and editor), Milwaukee 1968
Karl F. Schmidt, PhD (Associate Director for Radio [WHA] at University of Wisconsin), Madison .. 1969
The Most Rev. Father Carl Mansfeld, Milwaukee.. 1970
Roy T. Ragatz (Executive Director, Interstate Postgraduate Medical Association), Madison 1971

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes.

Past Presidents of the State Medical Society

Mason C. Darling, M.D., Fond du Lac.....1841–1847
John B. Dousman, M.D., Milwaukee.....1847–1849
Alfred L. Castleman, M.D., Delafield.....1849–1851
Harmon Van Dusen, M.D., Mineral Point...1851–1854
Alfred L. Castleman, M.D., Delafield.....1854–1855
John Mitchell, M.D., Janesville.....1855–1856
David Cooper Ayres, M.D., Green Bay.....1856–1857
Clark G. Pease, M.D., Janesville.....1857–1859
Ezra S. Carr, M.D., Madison.....1859–1861
Solomon Blood, M.D., Rochester.....1861–1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, M.D., Mineral Point....1867–1869
Solon Marks, M.D., Milwaukee.....1869–1870
Henry P. Strong, M.D., Beloit 1870–1871
John Favill, M.D., Madison.....1871–1872
Harmon Van Dusen, M.D., Mineral Point....1872–1873
Marvin Waterhouse, M.D., Portage.....1873–1874
James T. Reeve, M.D., Appleton.....1874–1875
Joseph B. Whiting, M.D., Janesville.....1875–1876
John K. Bartlett, M.D., Milwaukee.....1876–1877
Darius Mason, M.D., Prairie du Chien.....1877–1878
Nicholas Senn, M.D., Milwaukee.....1878–1879
John G. Meachem, Sr., M.D., Racine.....1879–1880
Ira Manley, Jr., M.D., Markesan.....1880–1881
William Meacher, M.D., Portage.....1881–1882
Thomas P. Russell, M.D., Oshkosh.....1882–1883
Nelson M. Dodson, M.D., Berlin.....1883–1884
Edwin W. Bartlett, M.D., Milwaukee.....1884–1885
G. M. Steele, M.D., Oshkosh.....1885–1886
Samuel C. Johnson, M.D., Hudson.....1886–1887
Leroy G. Armstrong, M.D., Boscobel.....1887–1888
John R. Barnett, M.D., Neenah.....1888–1889
Ezra M. Rogers, M.D., Hartford.....1889–1890
George D. Ladd, M.D., Milwaukee.....1890–1891
George F. Witter, M.D., Grand Rapids
(Wisconsin Rapids).....1891–1892
Benjamin T. Phillips, M.D., Menominee, Mich..1892–1893
Benjamin C. Brett, M.D., Green Bay.....1893–1894
Almon Clarke, M.D., Sheboygan.....1894–1895
Frank W. Epley, M.D., New Richmond.....1895–1896
B. O. Reynolds, M.D., Lake Geneva.....1896–1897
William Mackie, M.D., Milwaukee.....1897–1898
Herman Reineking, M.D., Milwaukee.....1898–1899
Wilbur T. Sarles, M.D., Sparta.....1899–1900
John F. Pritchard, M.D., Manitowoc.....1900–1901
Walter H. Neilson, M.D., Milwaukee.....1901–1902
John V. R. Lyman, M.D., Eau Claire.....1902–1903
Franklin E. Walbridge, M.D., Milwaukee.....1903–1904
Charles W. Oviatt, M.D., Oshkosh.....1904–1905
John R. Currens, M.D., Two Rivers.....1905–1906
Levi H. Pelton, M.D., Waupaca.....1906–1907
William E. Ground, M.D., Superior.....1907–1908
Gilbert E. Seaman, M.D., Madison.....1908–1909
Edward Evans, M.D., La Crosse.....1909–1910
Byron M. Caples, M.D., Waukesha.....1910–1911
John M. Dodd, M.D., Ashland.....1911–1912
Arthur J. Patek, M.D., Milwaukee.....1912–1913
Charles S. Sheldon, M.D., Madison.....1913–1914
Theodore J. Redelings, M.D., Marinette.....1914–1915
Louis J. Jermain, M.D., Milwaukee.....1915–1916
Hoyt E. Dearholt, M.D., Milwaukee.....1916–1917
Gustave Windesheim, M.D., Kenosha.....1917–1918
Dennis J. Hayes, M.D., Milwaukee.....1918–1919
Charles R. Bardeen, M.D., Madison.....1919–1920
Henry W. Abraham, M.D., Appleton*.....1920
Matthew A. McGarty, M.D., La Crosse.....1920–1921
Sidney Hall, M.D., Ripon.....1921–1922
F. Gregory Connell, M.D., Oshkosh.....1922–1923
Rock Sleyster, M.D., Wauwatosa.....1923–1924
Wilson Cunningham, M.D., Platteville.....1924–1925
Joseph F. Smith, M.D., Wausau.....1925–1926
Arthur W. Rogers, M.D., Oconomowoc.....1926–1927
John J. McGovern, M.D., Milwaukee.....1927–1928
Karl W. Doege, M.D., Marshfield.....1928–1929
Frederick J. Gaenslen, M.D., Milwaukee.....1929–1930
A. J. McDowell, M.D., Soldiers Grove†.....1930
Cornelius A. Harper, M.D., Madison.....1930–1931
Otho Fiedler, M.D., Sheboygan.....1931–1932
Reginald H. Jackson, M.D., Madison.....1932–1933
Stanley J. Seeger, M.D., Milwaukee.....1933–1934
Thomas J. O'Leary, M.D., Superior.....1934–1935
Ralph M. Carter, M.D., Green Bay.....1935–1936
Stephen E. Gavin, M.D., Fond du Lac.....1936–1937
James C. Sargent, M.D., Milwaukee.....1937–1938
Albert E. Rector, M.D., Appleton.....1938–1939
Raymond G. Arveson, M.D., Frederic.....1939–1940
Ralph P. Sproule, M.D., Milwaukee.....1940–1941
Gunnar Gundersen, M.D., La Crosse.....1941–1942
Francis E. Butler, M.D., Menomonie.....1942–1943
Russell M. Kurten, M.D., Racine.....1943–1944
Charles Fidler, M.D., Milwaukee.....1944–1945
P. R. Minahan, M.D., Green Bay.....1945–1946
Charles A. Dawson, M.D., River Falls.....1946–1947
William D. Stovall, M.D., Madison.....1947–1948
Karl H. Doege, M.D., Marshfield 1948–1949
John W. Truitt, M.D., Milwaukee.....1949–1950
Henry H. Christofferson, M.D., Colby.....1950–1951
Albian H. Heidner, M.D., West Bend.....1951–1952
Joseph C. Griffith, M.D., Milwaukee.....1952–1953
H. Kent Tenney, M.D., Madison.....1953–1954
Arthur J. McCarey, M.D., Green Bay‡.....1954–1955
Ervin L. Bernhart, M.D., Milwaukee.....1955–1956
L. O. Simenstad, M.D., Osceola.....1956–1957
Harry E. Kasten, M.D., Beloit.....1957–1958
Jerome W. Fons, M.D., Milwaukee.....1958
William B. Hildebrand, M.D., Menasha.....1959–1960
Edmund D. Sorenson, M.D., Elkhorn.....1960–1961
Leif H. Lokvam, M.D., Kenosha.....1961–1962
Nels A. Hill, M.D., Madison.....1962–1963
William J. Egan, M.D., Milwaukee.....1963–1964
William P. Curran, M.D., Antigo.....1964–1965
J. H. Houghton, M.D., Wisconsin Dells.....1965–1966
Frank E. Drew, M.D., Milwaukee.....1966–1967
H. J. Kief, MD, Fond du Lac.....1967–1968
W. D. James, MD, Oconomowoc 1968–1969
Robert E. Callan, MD, Milwaukee 1969–1970
Jerry W. McRoberts, MD, Sheboygan 1970–1971

* *Died during term of office as president-elect.*

† *Resigned, because of health, prior to taking office.*

‡ *Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year*

PRESIDENTS AND SECRETARIES, WISCONSIN SPECIALTY SOCIETIES

WISCONSIN ALLERGY SOCIETY

President—Abe Sosman, MD (May 1972), Milwaukee
Secretary—Jordon Fink, MD (May 1972), Milwaukee

WISCONSIN SOCIETY OF ANESTHESIOLOGISTS

President—P. A. Hoffman, MD (Oct. 1972), Madison
Secretary—Ruth A. Stoerker, MD (Oct. 1972), Madison

WISCONSIN DERMATOLOGICAL SOCIETY

President—R. R. Baumann, MD (Oct. 1972), Monroe
Secretary—H. V. Moss, MD (Oct. 1972), Madison

WISCONSIN ACADEMY OF FAMILY PHYSICIANS

President—P. E. Wainscott, MD (Sept. 1972), Menasha
Secretary—N. F. Damiano, MD (Sept. 1972), Hales Corners
Executive Secretary—Mr. Robert H. Herzog (Sept. 1972), Milwaukee

WISCONSIN SOCIETY OF INTERNAL MEDICINE

President—J. M. Irvin, MD (Sept. 1972), Monroe
Secretary—R. C. Puestow, MD (Sept. 1972), Manitowoc
Executive Secretary—Mr. Donald L. McNeil (Sept. 1972), Milwaukee

WISCONSIN NEUROLOGICAL SOCIETY

President—Philip T. White, MD (June 1972), Milwaukee
Secretary—Paul R. Dyken, MD (June 1972), Milwaukee

WISCONSIN SOCIETY OF OBSTETRICS AND GYNECOLOGY

President—Richard C. Brown, MD (Oct. 1972), Eau Claire
Secretary—W. J. O'Leary, MD (Oct. 1972), La Crosse

WISCONSIN ORTHOPEDIC SOCIETY

President—S. C. Rogers, MD (Sept. 1972), Madison
Secretary—J. M. Huffer, MD (Sept. 1972), Madison

WISCONSIN OTOLARYNGOLOGICAL SOCIETY

President—Roger Lehman, MD (Sept. 1972), Wood
Secretary—T. J. Donovan, MD (Sept. 1972), Madison

WISCONSIN SOCIETY OF PATHOLOGISTS

President—Chesley Erwin, MD (Nov. 1972), Elm Grove
Secretary—Roland C. Brown, MD (Nov. 1972), Milwaukee

WISCONSIN ACADEMY OF PEDIATRICS

President—J. R. Guy, MD (May 1972), Waukesha
Secretary—G. G. Griese, MD (May 1972), Marshfield

WISCONSIN SOCIETY OF PLASTIC SURGERY

President—Gordon Davenport, MD (no official term), Madison
Secretary—J. E. Hamacher, MD (no official term), Madison

WISCONSIN PSYCHIATRIC ASSOCIATION

President—W. H. Heywood, MD (May 1972), Marshfield
Secretary—D. T. Fullerton, MD (May 1972), Marshfield

WISCONSIN ASSOCIATION OF PUBLIC HEALTH PHYSICIANS

President—A. L. Van Duser, MD (May 1972), Madison
Secretary—Josef Preizler, MD (May 1972), Madison

WISCONSIN RADIOLOGICAL SOCIETY

President—Leslie Jones, MD (Sept. 1972), Fond du Lac
Secretary—Marvin Hinke, MD (Sept. 1972), Marshfield

WISCONSIN SURGICAL SOCIETY

President—B. R. Lawton, MD (May 1972), Marshfield
Secretary-Treasurer—Wilson Weisel, MD (May 1972), Milwaukee

WISCONSIN UROLOGICAL SOCIETY

President—T. H. McDonnell, MD (May 1972), Waukesha
Secretary—John D. Silbar, MD (May 1972), Milwaukee

DRIVERS' LICENSES FOR EPILEPTICS

A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Division of Motor Vehicles and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Division of Motor Vehicles. A denial may be reviewed, however, by a special board.

Reference: Section 343.09, Wisconsin Statutes.

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Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 979.121, Wisconsin Statutes.

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Adenocarcinoma of the Vagina in Young Women

The Stilbestrol-Adenosis-Adenocarcinoma of the Vagina Syndrome

WILLIAM C. FETHERSTON, MD
ALFRED MEYERS, MD
MARK E. SPECKHARD, MD
Milwaukee, Wisconsin

THE MOST STRIKING recent development in pelvic oncology is the discovery of an apparent relationship between maternal stilbestrol therapy and the subsequent development of adenocarcinoma of the vagina in the female offspring.

In 1970 Herbst and Scully[1] alerted physicians to a rare lesion which has occurred recently with unusual frequency and in an age group previously free from this disease. Their paper entitled "Adenocarcinoma of the Vagina in Adolescence" alerted physicians to an unusual cluster of clear-cell adenocarcinomas of the vagina in young women.

In April 1971 Herbst et al[2] revealed the association of maternal stilbestrol therapy with the appearance of this tumor in young women. Seven of the eight women with adenocarcinoma of the vagina reviewed in this paper had been subject in utero to the influences of stilbestrol administered to their mothers during pregnancy.

In August 1971 Greenwald et al[3] reported five additional cases from the New York area

Presented in part before the District VI Meeting of the American College of Obstetricians and Gynecologists, Madison, Wisconsin, October 1, 1971.

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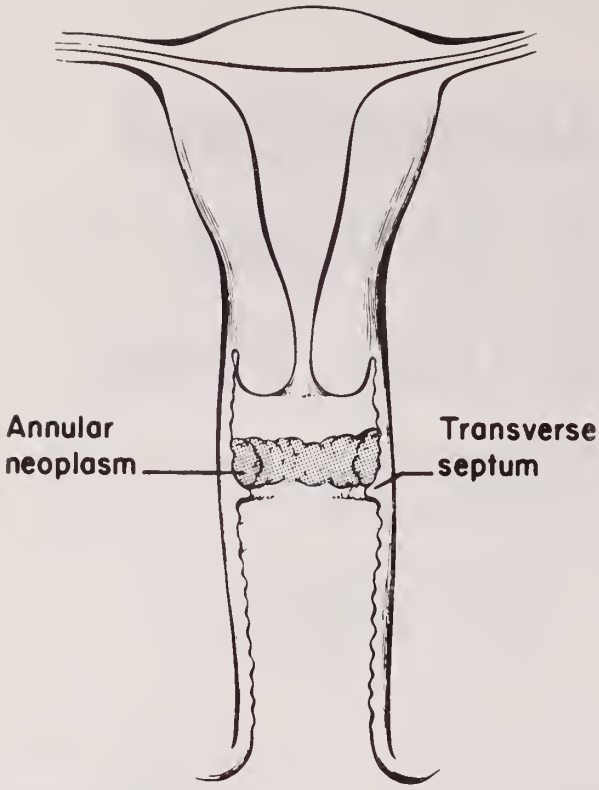


Figure 1—Diagrammatic representation of vaginal lesions in Cases 1 and 2.

of young women with adenocarcinoma of the vagina whose mothers had been given stilbestrol therapy.

In a personal communication in January 1972 Dr. Arthur L. Herbst noted that his group had already learned of 64 cases of genital adenocarcinoma in young females in the United States most of which have been linked to maternal hormone therapy.

The following is a case report of adenocarcinoma of the vagina in a young woman diagnosed and treated on the Tumor Service at St. Mary's Hospital in Milwaukee in May 1971.

CASE REPORTS

Case 1: An asymptomatic 19-year-old single white female was seen in May 1971 for a routine premarital examination. On pelvic examination she was noted to have a remnant of transverse septum at the juncture of the upper and middle third of the vagina. The upper third of the vagina contained multiple raised, frequently confluent vaginal lesions which were firm and nontender (Fig 1). The lesions circumscribed the vaginal canal but were clearly separate from the cervix. No lesions were found in the lower two-thirds of the vagina. The remainder of the pelvic examination was normal.

Biopsy of the vaginal lesions revealed a clear-cell adenocarcinoma (Fig 2) with the following characteristics. The pattern of this malignant epithelial neoplasm varied in different parts with tubular, solid, and papillary foci present. The lining cells often showed a hobnail or peglike character. Clear cells with mucin-negative cytoplasm were noted in glandular and solid zones. Multiple biopsies of the cervix and endometrial curettings were histologically normal.

The patient's mother gave a history of two abortions followed by the pregnancy in which our patient was in utero. During this pregnancy our patient was subject in utero to the influences of stilbestrol given to her mother because of her poor reproductive history. The mother was given 25 mg of stilbestrol daily beginning in the first trimester and this dosage was continued to term. The maternal and patient histories did not reveal any other carcinogenic stimulus. We treated the patient with external cobalt irradiation and two intracavitary radium

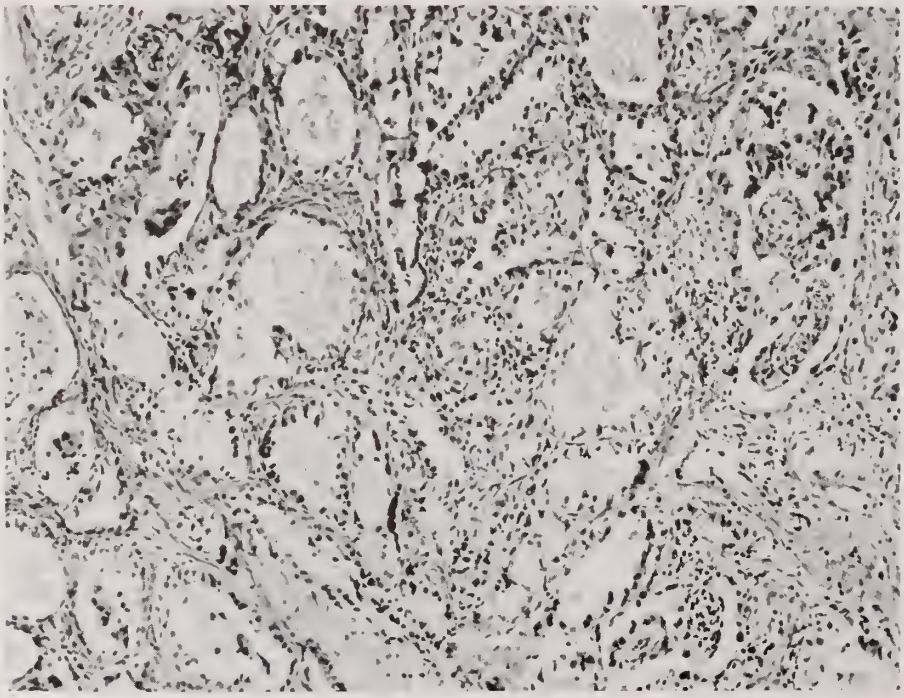


Figure 2—Vaginal biopsy of Case 1. Infiltrating adenocarcinoma with clear and hobnail tumor cells (H&E; X 100).

applications. At her most recent examination, five months post-irradiation, there was no evidence of recurrence and multiple biopsies of the upper vagina did not reveal residual tumor. She has married and has retained good vaginal function.

Benign adenosis may be an intermediate step in the stilbestrol–adenosis–adenocarcinoma syndrome. The following is a case report of a patient with benign vaginal adenosis diagnosed and treated at St. Mary's Hospital in June 1971. The similarities between these two cases seem striking.

Case 2: An asymptomatic 21-year-old single white female was seen in June 1971 for a routine premarital examination. A pelvic examination revealed a remnant of transverse septum at the juncture of the upper and middle third of the vagina. The upper one-third of the vagina revealed multiple raised, sometimes confluent, vaginal lesions which were nontender and firm (Fig 1). The lesions circumscribed the vaginal canal but were clearly separate from the cervix. No lesions were found in the lower two-thirds of the vagina. The remainder of the pelvic examination was normal. Multiple biopsies of the vaginal lesions revealed benign vaginal adenosis with the following characteristics. The vaginal lesions showed abnormalities of surface epithelium and the presence of glands (Figs 3 and 4). The glands often communicated with the surface. The surface epithelium was partly squamous, partly cylindrical, and in part combined epithelium. Some of the cylindrical epithelial cells were low columnar mucin-negative (Fig 5), but the majority were pickett cells with obvious mucin. The underlying glands were chiefly mucin secreting and closely resembled endocervical glands except for irregular crowding. Some showed squamous metaplasia. Occasional glands were lined by mucin-negative low cylindrical cells and resembled tubal epithelium. Although no gross lesions of the cervix were noted, biopsies of the cervix revealed that it contained a few subsurface mucin-negative glands. These were lined by low cylindrical partially ciliated epithelium with prominent deep-staining nuclei resembling tubal epithelium (Figs 6 and 7). Endometrial curettings did not reveal significant pathology.

History from the patient's mother revealed that during the pregnancy in which the patient was in utero, the mother was placed on 25 mg of stilbestrol daily during the first trimester because of previous reproductive failure. We are treating our patient with a progestational agent in the hope that this will minimize the effect her autogenous estrogen may have on the vaginal adenosis. It is planned to follow her with serial biopsies at two-to-three-month intervals until the lesion has cleared. At present the area involved seems too extensive for resection.

DISCUSSION

Cancer of the vagina has been a rare disease. It usually manifests itself as squamous cell carcinoma in the elderly. In an analysis of 68 cases of primary vaginal carcinoma seen at the Massachusetts General Hospital and the Pondville State Cancer Hospital (Massachusetts Department of Health) in a 36-year period through 1963, Herbst et al[4] found that the peak incidence of the disease occurred in women in the 50-to-70-year age group. The youngest patient treated in the series was 24 years old. Sixty-one of the 68 tumors were squamous cell carcinomas. Three cases were adenocarcinomas. Rutledge reviewed 101 cases from the M. D. Anderson Hospital and Tumor Institute and noted a similar distribution in patient age and cell type.[5]

Against this background, the cluster of cases of adenocarcinoma of the vagina in young women reported by Herbst and Scully in 1970

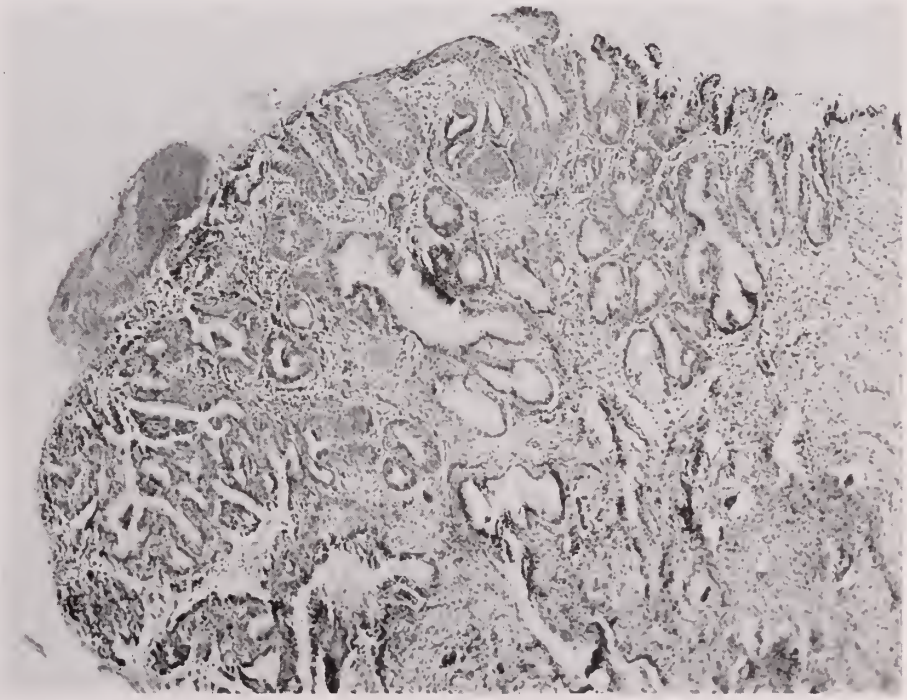
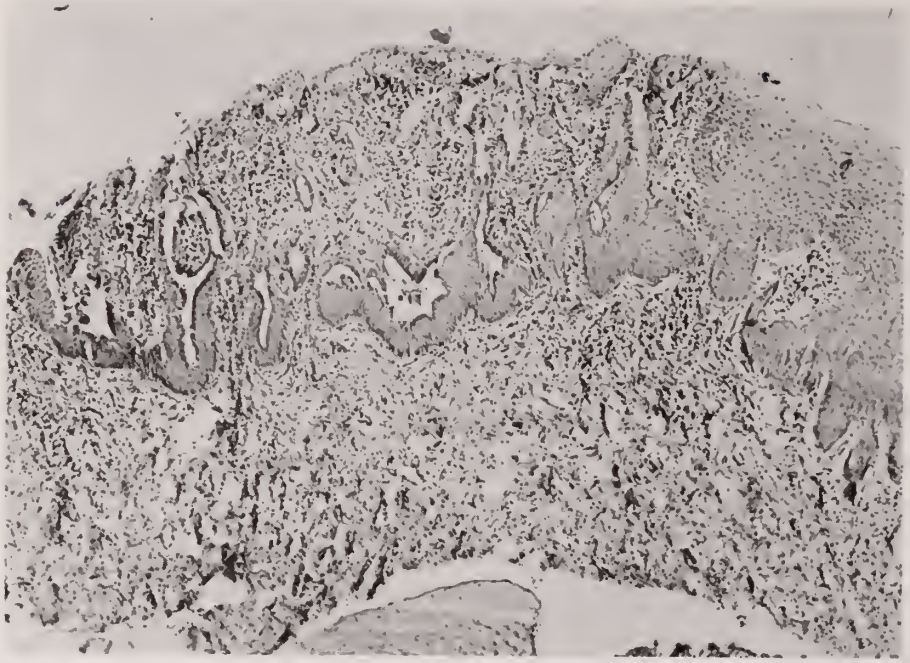
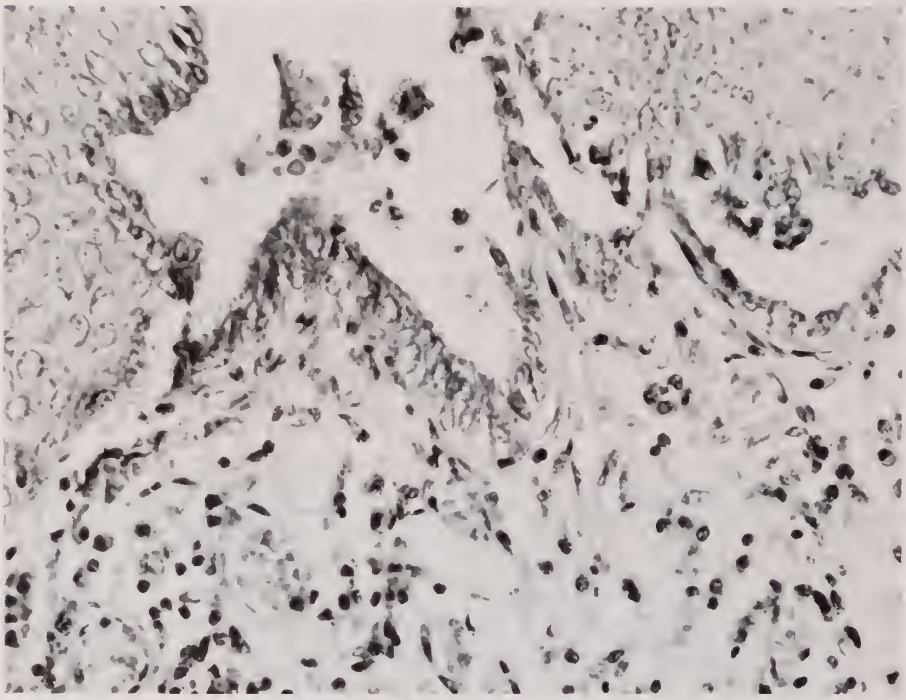


Figure 3—Vaginal biopsy of Case 2. Squamous and mucus-secreting surface epithelium and mucus-secreting glands resembling endocervical glands (H&E; X25).





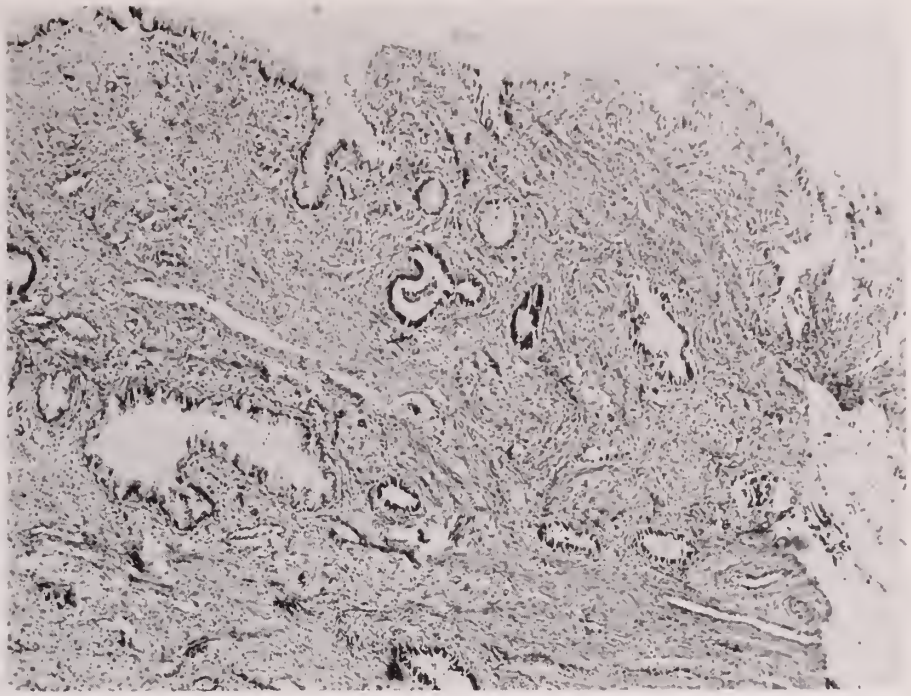
Figures 4 and 5—Vaginal biopsy of Case 2. Non-mucus-secreting low cylindrical glands (H&E; X25 and X400).

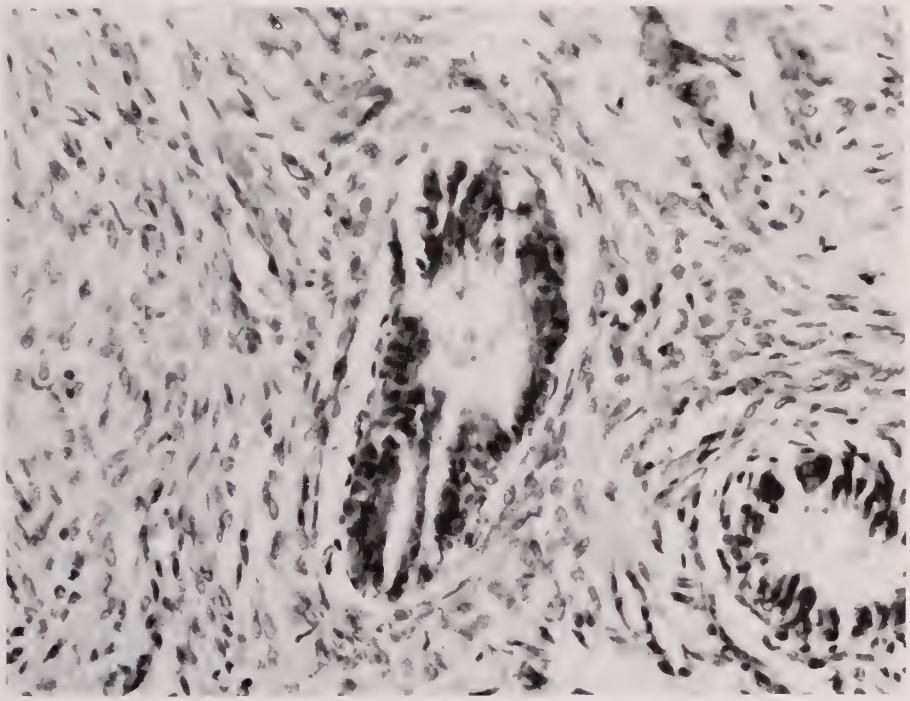
clearly represents an unusual occurrence. The unusual number of cases of vaginal carcinoma is accentuated by the uncommon cell type and unusual age distribution. Although some claim a mesonephric origin,[6] Scully and Barlow[7] have raised convincing evidence for the probable Muellerian origin of these clear-cell adenocarcinomas.

While adenosis vaginae has received little attention in standard gynecologic textbooks, Gardner and Kaufman give it deserving attention in their book entitled *Benign Diseases of the Vulva and Vagina.*[8] There are also good reviews of the subject in the literature.[9, 10, 11] The glands of adenosis vaginae may resemble those of the endocervix, the endometrium or even the endosalpinx.

Pathogenesis

It is interesting to reflect on the relationship between stilbestrol and adenosis and adenocarcinoma of the vagina. Stilbestrol is a synthetic nonsteroidal estrogen. Meissner et al[12] have demonstrated that stilbestrol is carcinogenic in the development of adenocarcinoma of the endometrium in the rabbit. Stilbestrol has not





Figures 6 and 7—Cervical biopsy of Case 2. Subsurface collection of nonmucus-secreting low cylindrical partially ciliated glands resembling tubal epithelium (H&E; X25 and X400).

been demonstrated to be carcinogenic in the human.

There was an era in recent decades in which stilbestrol was used in high doses in pregnancy in which there was threatening abortion or a history of abortions. Stilbestrol therapy in early pregnancy with transplacental transfer and continued stimulation of the receptor sites of the vaginal anlage during fetal development and especially during the critical period of organogenesis may be the initiating factor in this syndrome. The stilbestrol may influence the developing Muellerian apparatus in such a way that abnormal glandular tissue persists in the upper vagina.

The subsequent years during which estrogen stimulation is minimal might be considered the latent phase, terminated by the increased endogenous estrogen levels which occur at the menarche. It is not known whether patients manifesting the stilbestrol–adenosis–adenocarcinoma syndrome have overt adenosis in the vagina during this latent period.

Both our cases manifested a remnant of transverse septum in the vagina. The septum may

For a related editorial, "The Long Road," turn to page 35

mark the dividing line between vaginal development from the urogenital sinus in the lower two-thirds of the vagina and from Muellerian origin in the upper third. The vaginal adenosis and adenocarcinoma in our two cases was limited to the upper one-third of the vagina which would be consistent with albeit not indicative of an origin in Muellerian tissues.

Since Muellerian structures are sensitive to the influences of estrogen, we could expect that any abnormal glandular elements of Muellerian origin in the upper vagina might be sensitive to further estrogen stimulation. The surge of estrogen at the menarche and thereafter may be the precipitating factor causing patients with abnormal glandular elements to manifest overt vaginal adenosis. In adenocarcinoma of the vagina it has not been established at present whether the change is malignant from the beginning or represents a later malignant change in an abnormal glandular epithelium. The latter seems more likely.

Diagnosis

In several cases reported in the literature, delays in diagnosis were related to attributing abnormal vaginal bleeding in these young women to innocent causes such as anovulation. Since recognizing the stilbestrol–adenosis–adenocarcinoma syndrome, it becomes increasingly evident that young women with abnormal vaginal bleeding deserve a pelvic examination including a speculum examination with a close look at the vaginal mucosa. The risk of developing vaginal adenosis or adenocarcinoma in all young women who were subject to stilbestrol stimulation in utero is still unknown. Hopefully it will be a small proportion of such women who manifest this disease. Nevertheless it is important that asymptomatic young women who are known to have been subject to stilbestrol in utero receive special attention in the form of pelvic examination and close follow-up. Needless to say it will be important to reassure patients in this category, at least until their risk of developing adenocarcinoma can be better defined. At present that risk appears to be low.

Pap smears have not proven to be a reliable method of screening for this disease and three of the seven cases originally reported by Herbst and Scully had negative Pap smears.

Treatment

We have selected progesterone in the treatment of vaginal adenosis in the hope that we can minimize the effect of autogenous estrogen. Folkman also has suggested the use of progesterone in the treatment of vaginal adenosis in the hope that it might eliminate the adenosis and protect against the development of adenocarcinoma.[13] The effectiveness of this regimen must be evaluated.

As yet no optimum program has been defined for the treatment of adenocarcinoma of the vagina. Until the results of present surgical treatment programs can be fully evaluated, it is our concern that any surgical approach that leaves the rectum and the bladder also may leave residual tumor in their supporting fascias which are in such close approximation to the vagina. Rather than choose total pelvic exenteration for these young women, we have selected irradiation as our treatment of choice at this time in the hope that we can preserve a functional pelvis and intact gastrointestinal and urinary tracts. We are hopeful that this can be accomplished without a reduction in cure rate. Time should resolve many of these questions.

In order to better understand this syndrome, its pathogenesis and epidemiology (and perhaps ultimately to review and compare treatment programs and results), it has been suggested that case reports be submitted to a central clearing house where all cases can be reviewed and data accumulated.[14] Such a registry has been established as indicated in a letter to the editors of *The New England Journal of Medicine* by Herbst, Ulfelder, and Poskanzer.[15] All inquiries and communications should be addressed to: Arthur L. Herbst, MD, Department of Gynecology, Massachusetts General Hospital, Boston, Mass. 02114.

In a subsequent letter to the same editors these authors comment on some trends already evident as follows:[16] "One may with considerable confidence now predict that a map showing the places of birth of young women with adenocarcinoma of the vagina will indicate a tendency for them to cluster. Moreover, the areas of greatest density will surely coincide with those where stilbestrol, at least for an interval, was a preferred treatment for high-risk pregnancy two decades ago."

CONCLUSIONS

Recognition of the stilbestrol–adenosis–adenocarcinoma syndrome prompts the following observations:

- Abnormal vaginal bleeding in a young woman deserves a pelvic examination including a speculum examination with a close look at the vaginal mucosa.
- Any female who was subject in utero to the influence of stilbestrol warrants close follow-up (in a reassuring atmosphere).
- Stilbestrol would appear to be contraindicated in pregnancy.
- The Pap smear is not a reliable screening test for adenocarcinoma of the vagina.
- Reporting of cases of adenocarcinoma of the vagina to Doctor Herbst may lead to a better understanding of the pathogenicity and epidemiology of this syndrome.

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Operative Blood Flow in Femoral-Popliteal and Femoral-Tibial Grafts for Lower Extremity Ischemia

V M Bernhardt, MD et al, The Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 103:595–599 (Nov) 1971

Blood flow through femoral-popliteal vein grafts in 15 extremities was compared with flow through 14 femoral-tibial grafts at the time of surgery. Average baseline flow was 98 ml/min in the femoral-popliteal and 99 ml/min in the femoral-tibial group. Intra-arterial papaverine produced an increase in average flow up to 176 ml/min in the former and 162 ml/min in the latter group, and the difference was not statistically significant. The effect of subsequent occlusion or patency, the presence of diabetes, clinical severity of ischemia, and angiographic staging of runoff, were correlated with graft flow within each group and between the two groups. A statistically significant adverse correlation could not be demonstrated for any of these factors.

These studies further support the use of bypass grafting to the tibial or peroneal arteries for limb salvage when the popliteal is not available for the distal anastomosis. Diabetes does not appear to reduce flow in the runoff bed, and it should not be considered a contraindication to bypass surgery. □

Respiratory Care in Acute Botulism: Report of Four Cases

J C Paust, MD, University of Wisconsin Medical School, Madison, Wis: *Anesth & Analg Current Res* 50:1003–1009 (Nov–Dec) 1971

Four cases of acute intoxication from type A botulism food poisoning in one family are presented. Three of the four required prolonged ventilatory support for 14, 55 and 88 days respectively. All four survived and have regained their former state of good health. The botulism toxin denervates its victims by interfering with the release of acetylcholine at the neuromuscular junction in a manner similar to the presynaptic blockade seen with low calcium or high magnesium. Patients present with acute cranial nerve impairment and symmetrical descending weakness or paralysis. Pupils may be fixed and dilated without central nervous system disturbance. Tachycardia and adynamic ileus may complicate the disease course. Successful treatment with full recovery of all neurologic function is possible even in the most severe cases if adequate supportive measures are maintained until bound toxin can be eliminated. Botulism antitoxins are used to eliminate circulating toxin. Guanidine, a recent innovation in the treatment of botulism, increases the amount of acetylcholine released from nerve endings by a single nerve impulse. However, results with guanidine in the four cases presented here were disappointing primarily because of the side effects of the drug and the severity of the patients' illnesses. □

Airway Problems in the Recovery Room

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AIRWAY PROBLEMS arise most frequently during the immediate postoperative period. At the termination of a surgical procedure when the patient is recovering from anesthetics, the laryngeal and pharyngeal reflexes become too active to tolerate artificial airways (oropharyngeal airways and endotracheal tubes) which must then be removed. However, after arrival in the recovery room with no stimulation, he may return to the somnolent state due to the residual effect of anesthetic and preanesthetic agents; and his airways may become obstructed.

Relaxation of soft tissue is the most common cause of upper airway obstruction at this stage, particularly in aged and edentulous patients. When subatmospheric pressure is created in the mouth during inspiration, the relaxed lips, cheeks, and tongue can be partially or completely sucked in, obliterating the air passages.

A patient with a short neck, large tongue, small chin or flat epiglottis is most likely to present airway problems. In some instances the obstruction may be relieved by hyperextension of the neck and forward displacement of the mandible; in others, a nasopharyngeal airway (a short endotracheal tube inserted through the nose down to the pharynx) may be well tolerated.

Patients who have had operations within the oral cavity, the pharynx, larynx, and on the neck present special problems and require particular attention. Laryngeal irritation from mucus and blood can be removed by careful suctioning, but a more serious laryngeal complication—edema due to trauma—demands specific treatment. For the patient who has an artificial airway in place during his recovery from anesthesia, proper care is required to maintain patency of the artificial airway and to adequately humidify the inspired air. The following cases represent different problems of the upper airway during the immediate postoperative period.

A. COMPLICATIONS OF HEAD AND NECK OPERATIONS

1. *Hematoma and edema of the floor of the mouth and oropharynx*

Following operative procedures of the mandible, palate and pharynx, the patient's airway may become obstructed immediately after extubation of the endotracheal tube, or gradually with the formation of edema and hematoma. In some instances, obstruction is due to blood clots and thick secretions which can be readily removed by careful suctioning.

Case Report. A 79-year-old man with carcinoma of the lower lip had undergone a partial resection (1½") of the left mandible with excision of cervical nodes under general anesthesia (halothane-N_2O-O_2) of one and one-half hours' duration. The intraoperative course was uneventful, and the endotracheal tube was removed at the end of the surgical procedure as the patient was awakening from anesthesia. Approximately one hour after the patient arrived in the recovery room he became progressively restless, dyspneic, and cyanotic. Reintubation was performed with extreme difficulty due to swelling of the oropharyngeal tissues. Meanwhile, the patient became deeply cyanotic and unconscious, and never regained consciousness after resuscitation. He developed a left hemiplegia ten hours later and died ten days after the operation.

COMMENT: This case was regarded as a relatively minor procedure with minimal amount of trauma; therefore, severe pharyngeal edema was totally unexpected. Restlessness should be taken as the first sign of hypoxia and not as the need for pain medication. Administering oxygen by mask should precede the attempt of endotracheal intubation or tracheotomy to avoid severe hypoxia with irreversible damage.

2. *Hematoma and swelling of the neck compounded by tight surgical dressings*

Ventilatory difficulty in these cases is due to tracheal compression and obstruction. Hematoma may develop unnoticed under thick bandages, and the warning signs are those of hypoxia such as restlessness, increasing cyanosis and changing pulse rate. The following case represents an airway complication following a procedure on the carotid artery, in which instance evacuation of hematoma was necessary to gain airway patency.

Case Report. A 19-year-old girl was admitted for evaluation of epileptic convulsions. Carotid arteriogram was done under local anesthesia. In the recovery room she developed inspiratory stridor and repeated attacks of grand mal seizures which could not be controlled with anti-epileptic drugs. A moderate amount of neck swelling was noted, and evacuation of a large hematoma in the neck relieved the respiratory difficulty and brought the seizures under control.

Reprint requests to: Nancy Wu, MD, Assistant Professor, Department of Anesthesiology, University of Wisconsin Medical Center, 1300 University Ave, Madison, Wis. 53706.
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COMMENT: The respiratory difficulty of this patient was originated from tracheal obstruction by a hematoma. Epileptic attacks were apparently precipitated by hypoxia following airway obstruction and by anxiety with increasing oxygen demand. The onset of dyspnea should be regarded as a warning sign of tracheal compression which calls for immediate relief of tension.

3. *Post-thyroidectomy*

These patients present airway problems in several ways. The recurrent laryngeal nerves may be accidentally severed with consequent paralysis of the vocal cords. Hemorrhage or edema of the neck under tight dressings causes tracheal compression. When thyroidectomy is combined with radical neck dissection, impaired venous drainage of the neck and resultant swelling of the laryngeal and pharyngeal structures produce obstruction to air flow.

Case Report. A 21-year-old woman with a diagnosis of adenocarcinoma of the thyroid with metastasis to the neck nodes underwent a total thyroidectomy, right radical neck dissection and modified left radical neck dissection. This five-hour procedure was accomplished while the patient was anesthetized with thiopental, curare, and N_2O-O_2 via an endotracheal tube with controlled respiration. Plastic catheters with suction were inserted for drainage. Post-extubation-laryngoscopy revealed that the epiglottis and periepiglottal tissue were edematous but both vocal cords moved, the left side being more active than the right.

After arrival in the recovery room, fully conscious, the patient developed persistent inspiratory stridor. She was immediately given 4 mg of dexamethasone (Decadron®) intravenously, followed by another 8 mg a few minutes later and 8 mg repeated during the next four hours. A high output vaporizer was used to provide a highly humidified, oxygen-enriched, inspiratory mixture; and the head of the cart was elevated to facilitate venous drainage.

The patient was reassured and encouraged to breathe slowly, and the inspiratory stridor was improved. During the night, 12 hours postoperatively, the patient complained of difficulty in breathing and became very apprehensive. Although phonation was heard during inspiration, she appeared to be moving air well. After intramuscular administration of 75 mg of meperidine, her respiratory rate slowed, and there was some improvement of breathing difficulty. This partial airway obstruction gradually cleared up during the next four days.

COMMENT: This patient's airway difficulties improved with supportive treatment during the immediate postoperative period. Twelve hours later the recurrence of laryngeal irritation was worsened by rapid breathing secondary to apprehension. The effect of narcotics, which reduces the respiratory rate and allays apprehension, is beneficial in mild airway obstruction.

4. *Subcutaneous and mediastinal emphysema*

This complication may result from tracheostomy and neck operations[1,2] and traumatic endotracheal intubation.[3] Review of the anatomy reveals a communication between the neck structures and the superior mediastinum in the lower cervical region where the trachea and esophagus lie within two layers of cervical fasciae. The pretracheal layer of the deep cervical fascia may be incised or torn during operative procedures, and air finds its way into the mediastinum and the neck when the thoracic pressure is lowered during inspiration. The air is entrapped, compressed, and spread when the inlet is closed during expiration. In the case of traumatic endotracheal intubation, positive pressure breathing may force the gases through a mucosal tear in the piriform sinus into the areolar tissue in the tracheo-esophageal sulcus.

Case Report. An 8-year-old boy with lymphosarcoma of the neck underwent excision of the tumor and prophylactic tracheostomy. In the recovery room the patient developed increasing respiratory difficulty with subcutaneous emphysema of the neck. He was immediately taken back to the operating room where the tracheotomy tube was found to be partially displaced, and the trachea was deviated to the left. The recovery was uneventful after a revision of the tracheostomy.

COMMENT: Airway obstruction in this patient, due to partial obstruction of the trachea from the displaced tracheotomy tube and compression of the trachea from subcutaneous emphysema, can progress very rapidly. Immediate attention saved this patient from irreversible damage.

5. *Anomaly of the mandible*

Airway obstruction complicates the induction and emergence of anesthesia in the patient with congenital anomaly of the mandible.

Case Report. A 6-year-old girl with congenital anomaly of a mandibulofacial dysostosis was to undergo a palatoplasty. Having a large tongue and a very small chin, the patient's airway became obstructed almost immediately upon induction of anesthesia (halothane-N_2O-O_2). The obstruction was relieved with the use of a long oropharyngeal airway; however, attempt of endotracheal intubation was not successful even after she was given 40 mg of succinylcholine for relaxation. The anesthesia was then switched to ether-N_2O-O_2, and an oral endotracheal intubation was accomplished. The remainder of the anesthetic course and the palatal repair were uneventful.

After recovery and the removal of the endotracheal tube, the patient again became obstructed. The obstruction was more pronounced when the patient dropped off to sleep, but adequate airway could be maintained when she was aroused and when she was placed in the prone position. The patient was put in a humidified tent to receive high humidification and was given steroids to minimize the highly probable laryngeal and palatal edema. Under close observation throughout the night, she did not exhibit further difficulty.

COMMENT: Patients with hypoplasia of the mandible present airway problems during sleep because the small chin carrying the tongue tends to fall backward and occlude the pharyngeal airway. Prone position allows the tongue to fall forward and the blood and mucus to drain.

B. LARYNGEAL IRRITATION AND EDEMA

These are the complications of laryngoscopy and biopsy, bronchoscopy, and traumatic endotracheal intubation. The larynx may be traumatized by an over-sized endotracheal tube or by strenuous respiratory movement which causes friction between the larynx and the tube. Laryngeal edema may occur as a part of generalized edema resulting from overhydration[4] and positive pressure breathing. Subglottic edema is a serious complication in young children.[5,6] Hoarseness and croupy cough are symptoms of mild subglottic edema; more severe cases

exhibit stridor, suprasternal and intercostal retraction, laborious respiration, tachycardia, anxiety and restlessness.

Case Report—No. 1. This 8-year-old boy with a diagnosis of grade III Hodgkin's disease was to undergo parasternal exploration and biopsy of lymph nodes. He was anesthetized with thiopental, succinylcholine, N_2O and O_2. The No. 30 Murphy tube inserted into his trachea was a tight fit. In the recovery room the patient became croupy with suprasternal retraction which became worse when he cried. Dexamethasone, 4 mg, was given intravenously for laryngeal edema and 25 mg diphenhydramine (Benadryl®) for sedation. He was placed in a humidified tent during the next two days with marked improvement.

Case Report—No. 2. A 71-year-old man underwent transurethral resection of the prostate under halothane-N_2O-O_2 endotracheal anesthesia without incident. Two hours after the operation, awake and cooperative, he developed chills which progressed to shivers with rising temperature. He started to hyperventilate with inspiratory stridor and became very apprehensive. Treatment consisted of a highly humidified oxygen-air-mix through a face tent in addition to definitive measures for the type of febrile reaction not infrequently seen following transurethral prostatic operations. The arterial blood gases showed mild metabolic acidosis which was corrected with $NaHCO_3$ intravenously. The recovery was uneventful.

COMMENT: Laryngeal trauma may be attributed to an over-sized tube in Case 1, but laryngeal irritation may occur with nontraumatic endotracheal intubation. In most patients, signs of laryngeal irritation are preceded and exaggerated by pain, anxiety, and hyperventilation. This mild form of irritation subsides readily after the patients are put on mild sedation and humidified, oxygen-enriched inspiratory mixture plus specific treatment for underlying surgical complication.

C. PROBLEMS OF THE ARTIFICIAL AIRWAYS

Placing an artificial airway does not insure the patient a clear air passage.[7] The oropharyngeal airway and endotracheal tube may be occluded by blood clots, mucous plugs, and tumor debris. A soft endotracheal tube may be obliterated from outside by kinking and compression. If the tube is not affixed properly, it may be displaced to the esophagus, pharynx or pushed down to the main stem bronchus.

Case Report. A 9-year-old boy was admitted to the emergency room for a fractured right elbow, reportedly having not eaten anything during the last four hours. He was brought up to the operating room a short while later to have a closed reduction of the fractured elbow. Under thiopental and N_2O-O_2 anesthesia, the procedure was accomplished without difficulty except a slight airway obstruction which necessitated the insertion of a metal oropharyngeal airway. This maneuver caused the patient to cough, and the metal airway was removed. It was found that a piece of gum completely occluded the tip of the metal airway.

COMMENT: Foreign body in the mouth is not an uncommon cause of airway obstruction in children. When obstruction has been observed with an artificial airway in place and the air flow cannot be improved after suctioning with a well lubricated catheter of proper size, the artificial airway should be removed and replaced by another one if necessary.

DISCUSSION

Prophylactic measures for maintaining clear air passages and easy ventilation should be used in patients recovering from anesthetic and surgical operations. The patient should be placed in the lateral position. The tongue tends to fall away from the pharynx and blood, mucus, and vomitus are allowed to drain by gravitation when the patient's head is turned to the side. Prone position with the head turned to the side and a pillow under the hip can be used in children especially after tonsillectomy and adenoidectomy. Humidified, oxygen-enriched inspiratory mixture should be provided to patients with expected laryngeal irritation and to those with endotracheal tubes or a tracheostomy in place. Young children can better be managed in a humidified tent. Pain medication may be given in a reduced dosage such as ⅓ to ½ of a normal dose, to avoid the additive effect of anesthetic agents with resultant respiratory depression.

Severe airway obstruction should be detected promptly and immediate attention given. Hypoxemia develops rapidly in a young child whose metabolic demand is high and whose lung capacity is small. Irreversible damage to the vital organs may begin after a few minutes of oxygen deprivation in the aged and in patients with impaired cardiopulmonary function.

Partial or mild airway obstruction may clear spontaneously as the patient returns to the conscious state, or it may become more severe as the course enters a vicious cycle. Normally, the oxygen cost of breathing at rest constitutes only a small portion of the total oxygen uptake. It is greatly increased with airway obstruction and consequent increased work of breathing.[8,9] With further rising oxygen demand from pain and anxiety, restlessness and fever, the respiratory rate increases; and greater breathing effort is required to move air through the already narrowed air passage (Fig 1).

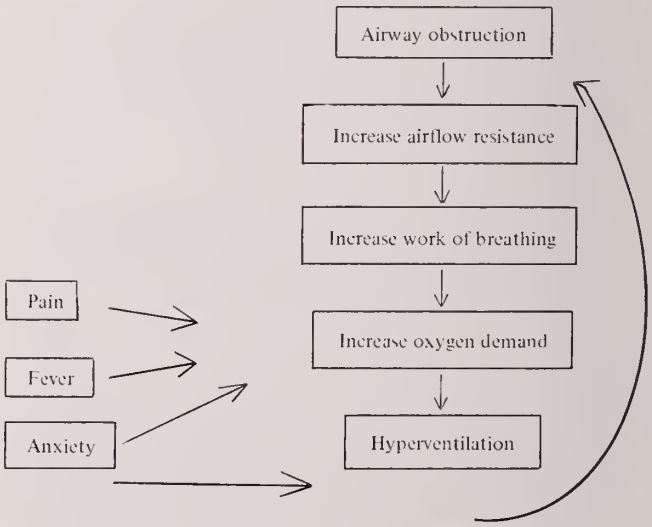

Figure 1—Vicious cycle of airway obstruction.

A companion article, "Postoperative Respiratory Failures," follows on page 98

Treatment should be preceded by detecting the cause of obstruction; although, in some instances intubation or tracheostomy is the only means of obtaining immediate relief. A few hours of conservative treatment may be tried in patients with laryngeal edema, particularly in young children who present technical difficulty for tracheotomy and greater hazard in posttracheotomy complication. Follow-up should include vigilant observation of clinical signs and serial determinations of arterial blood gases which provide guidance to the need for more aggressive measures. In addition to the signs of respiratory difficulties—dyspnea, cyanosis, substernal retraction, and use of accessory muscles—a host of other symptoms and signs are associated with hypoxemia and hypercapnia. One should watch for abnormal deviations of blood pressure, heart rate and rhythm, and the mental status of the patient to detect the stress of oxygen want and carbon dioxide retention.

Treatment for laryngeal edema and irritation consists of providing high humidity to the inspired air, adequate hydration, and parenteral administration of steroids—dexamethasone is the choice for its rapid anti-inflammatory action.[10] A single dose of up to 4 mg for infants under one year of age and 8 mg for children of the older age group can be administered intravenously. Mild sedation may be induced with intravenous or intramuscular injection of diphenhydramine (Benadryl®). In patients who have returned to a fully conscious state, small doses of narcotics are carefully utilized for their beneficial effects of reducing the respiratory rate and air flow resistance, as well as relieving pain and apprehension. Large doses of narcotics are to be condemned, for respiratory failure may be precipitated by central depression plus increased airway obstruction from soft tissue relaxation.

Suctioning of blood and secretion via the endotracheal tube should be preceded by allowing the patient to take a few breaths of oxygen followed by reinflation of his lungs with resuscitative bag after suctioning. Hematomas of the neck and pharynx are likely causes of airway obstruction following an operation on these areas, and evacuation of a hematoma under some circumstances may be the first lifesaving procedure to relieve tracheal and laryngeal obstruction. However, time should not be wasted by fruitless attempts at endotracheal intubation, as artificial respiration can be done in many instances with oropharyngeal airway, bag, mask, and oxygen. Prophylactic tracheostomy assures a free airway, performed after certain operations such as partial or total mandibulectomy and surgical excision of recurrent laryngeal nerves with paralysis of vocal cords.

SUMMARY

Airway problems which may lead to acute respiratory and circulatory failure during the immediate postoperative period are reviewed. Illustrative cases represent (1) complications of head and neck operations, (2) laryngeal trauma, and (3) problems of artificial airways. The pathophysiology of airway obstruction is discussed and the treatment outlined.

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Pseudomonas Septicemia Illustrated Evolution of Its Skin Lesion

G J Dorff, MD, N F Geimer, MD, D R Rosenthal, MD, and M W Rytel, MD, Medical College of Wisconsin, Milwaukee, Wis: *Arch Intern Med* 128:555–560 (Oct) 1971

A patient was presented with typical Pseudomonas skin lesions occurring as a result of Pseudomonas septicemia. The skin lesions were described and microscopic and gross lesions were illustrated. Pathophysiology of the skin lesions was discussed and a brief review of the literature presented. Specific treatment of Pseudomonas sepsis can be started earlier if this lesion is recognized by clinicians. □

Postoperative Respiratory Failure

NANCY WU, MD
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DESPITE ADVANCES in clinical medicine, the overall incidence of postoperative pulmonary complications has remained about the same in the past 30 years. However, many of the causative factors and the characteristics of the surgical patient population are different.[1] Poor risk patients with serious underlying diseases, previously denied the advantages of surgery, are now being operated on, and the clinicians have become more aware of postoperative respiratory problems. The successful application of mechanically supported ventilation in treating poliomyelitis led to the rapid expansion of respiratory therapy and its universal acceptance. The mortality rate of acute respiratory failure has shown a steady decline under present-day respiratory care.[2]

Ventilatory function may be greatly impaired following surgical operation. A reduction of ventilatory reserve of 50% or more has been observed on the first two days after an uncomplicated upper abdominal procedure,[3] and postoperative hypoxemia may last as long as 10 to 11 days.[4] On the other hand, metabolic demands are increased by tissue trauma causing greater energy expenditure and by fever and infection.[5] When the ventilatory reserve cannot meet the metabolic demands, the arterial blood oxygen tension falls, and carbon dioxide accumulates in the tissue fluids.

The following is a brief review of factors which may exhaust the ventilatory reserve.

Residual effects of general anesthesia may cause hypoventilation as well as airway obstruction, and pain medication produces further depression of respiratory center. As the cough reflex and the ciliary movement of tracheo-bronchial mucosa are inhibited and muscular tone is weakened after general anesthesia, secretions accumulate in the airways and predispose to atelectasis. Hypoventilation favors small airway closure and collapse of the lung units, especially in the supine position. This effect is most significant in elderly patients who, due to loss of elastic recoil of lung tissue, require larger tidal volumes to maintain patency of small airways.[6]

Respiratory excursion is impaired by a variety of causes including abdominal distention, peritoneal inflammation, tight dressing on chest and abdomen, and incisional pain. Restraining the patient on his back with arms extended greatly restricts the respiratory movement.

Loss of functional lung tissue may result from pulmonary resection, atelectasis, pneumonia, and hemo- or pneumothorax with lung collapse. Postoperative respiratory insufficiency is a familiar problem to the thoracic surgeons.

Patients with *preexisting pulmonary diseases* and impaired pulmonary function are undoubtedly more susceptible to postoperative pulmonary problems. These diseases include chronic obstructive pulmonary diseases, severe obesity, chest deformities, diffuse interstitial fibrosis, heart disease with pulmonary congestion and hypertension. Patients with myxedema, thyrotoxicosis and cirrhosis of the liver may have abnormalities of blood-gas exchange function.[7]

Post-traumatic pulmonary insufficiency is a recently described syndrome which occurs in patients following severe non-thoracic trauma, hemorrhagic shock, fat embolism, blast injury, pulmonary contusion, thermal burns and sepsis.[8] Various names have been used for this syndrome including shock lung, wet lung, pump lung, transfusion lung, respirator lung, and Da Nang lung. The disordered physiology, resulting in progressive pulmonary consolidation and hypoxemia is caused by the interplay of multiple factors. The pulmonary microcirculation is hindered by hypoperfusion with stagnation of blood flow, thromboembolism, and reflex arteriolar spasm. Thermal burns and smoke inhalation and other pulmonary trauma produce direct injury to the airways and lung parenchyma. Pulmonary shunting under these circumstances is mostly attributed to ventilation—perfusion mismatching as well as by blood passing through airless lung units caused by atelectasis, interstitial edema or air spaces filled by fluid or blood. The lungs are rendered more vulnerable to fluid overload, over-transfusion with blood, oxygen toxicity, and bacterial invasion.

Postoperative respiratory failure may develop rapidly in a matter of hours or insidiously over a period of days. Its more exaggerated form can be recognized easily, but a gradually developing respiratory failure is rarely diagnosed before pulmonary changes are radiologically evident and manifestations

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of severe hypoxemia are clinically apparent. The usual methods of evaluating ventilatory adequacy such as observation of chest motion and auscultation of air exchange are unreliable.

Cyanosis appears when the arterial blood is about 80% saturated; its absence does not rule out respiratory insufficiency. Tachycardia and hypotension are nonspecific but significant signs which are associated with hypoxemia particularly in severely ill patients. Cerebral hypoxia and hypercarbia are exhibited by restlessness, irritability, headache, sweating, involuntary movements, and changes in the level of consciousness.

In hospitals where elaborate pulmonary function tests are not available, arterial blood–gas measurements provide valuable information. For practical purposes, acute respiratory failure is present when arterial blood oxygen tension is below 60 mm Hg, or arterial CO_2 tension is above 50 mm Hg and the pH is below 7.35.

Successful management of postoperative respiratory failure depends upon preoperative assessment, prevention, and early recognition. Appraisal of a patient's preoperative status should start with a careful history taking and a thorough physical examination. Evaluation of ventilatory function can be made with a single breath test using a simple instrument—timed vitalometer[9] or a recording spirometer. Forced expiratory volume (FEV) obtained before and after the administration of a bronchodilator provides considerable information regarding the nature and extent of ventilatory insufficiency. When ventilatory test is found abnormal, arterial blood gases should be examined to detect preexisting hypoxemia and hypercapnia.

In patients with potential pulmonary problems, preoperative preparation should include control of respiratory infection, cessation of smoking, adequate use of bronchodilators, and reduction of airway secretions as well as chest physical therapy with emphasis on training in breathing exercises and coughing. This regimen has been demonstrated to reduce the postoperative morbidity and mortality and to shorten the hospital stay.[10]

During the early postoperative period, respiratory supportive measures to correct hypoventilation are mandatory in patients with impaired pulmonary function and with severe obesity. Since most critically ill patients have multiple organ failure, they should be evaluated for disturbed pulmonary, circulatory, and renal functions as well as other related problems. When the potential complications are recognized and corrected early, irreversible changes may be prevented.

An intensive care unit offers the patient constant monitoring and the care of specially trained nurses and respiratory therapists at all times; and a physician on duty can be called when problems arise. The key to good patient care is close communication and cooperation of multiple disciplines for no physician is knowledgeable in all medical fields and skilled in all life-support techniques.

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Considerations in the Development of a Predictive System for Cancer Chemotherapy

W H WOLBERG, MD, University of Wisconsin Medical Center, Madison, Wis: *Arch Surg* 102:344–347 (April) 1971

Experience with human responses to antitumor drugs and with cultures of 5-fluoro-2'-deoxyuridine sensitive NLSL tumor cells exposed to the drug has demonstrated that several factors which are not evaluated in predictive tests may affect the clinical response of tumors to drugs. Such factors lead to discrepancies between the *in vitro* assessment of response and that actually obtained in the patient. Studies with the fluorinated pyrimidines indicate that the cells must be biochemically sensitive before response can occur. However, biochemical sensitivity may exist and yet no tumor regression occurs when the drug is given to the patient. Tumor cells may be killed but their destruction may be masked in at least two ways: killed, sensitive cells may be replaced by fibrous tissue, or drug-resistant cells present in the original tumor may rapidly assume dominance when the sensitive cells are killed. In either case, significant tumor response to drug may escape detection. □

Comments on Treatment

Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Therapy with High Doses of Vitamins

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THE PRIMARY THERAPEUTIC USE of vitamins is to correct the respective deficiencies which are usually due to an insufficient dietary intake. The required doses are relatively small and in most cases the deficiencies are readily corrected. However, in the last few years conditions have been described in which vitamins are used at much higher doses than required for the nutritional needs. In some instances, as in the recent promotion of ascorbic acid for prevention or treatment of colds, the premise for the increased doses may be controversial and not generally accepted. In other conditions, the need for high vitamin doses has been proven and the treatment may be life-saving.

There are three main groups of diseases in which vitamins are regularly used at doses higher than suggested in the recommended daily dietary allowances:

1. Hereditary vitamin-dependent diseases
2. "Iatrogenic" vitamin deficiencies
3. Other conditions, in which high doses of vitamins seem to be of value but the rationale is not clear.

1. Hereditary vitamin-dependent diseases

In 1954, Hunt *et al* described *intractable convulsions* which appeared in an infant three hours after birth and, therefore, could not be associated with

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nutritional deficiency. The convulsions were controlled by high doses of *pyridoxine*. Further studies of the infant led to the conclusion that the condition represented a genetically determined error of metabolism involving pyridoxine. This report was probably the first documented description of vitamin-dependent genetic disease. Since 1954, this condition has been found in nearly 50 infants, with the onset of convulsions starting from three hours to seven days after birth and the therapeutic dose of pyridoxine required for their control ranging from 10 to 100 mg. The continuing daily maintenance dose is 5 to 25 mg, as compared with 1 to 2 mg daily requirement of normal infants of comparable age. The exact metabolic block associated with the increased requirement for pyridoxine is not known at this time. However, it has been suggested that the affected infants may have defective glutamic acid decarboxylase, the enzyme which catalyses the conversion of glutamic to aminobutyric acid.

Other inborn errors of metabolism characterized by higher needs for pyridoxine are *homocystinuria* and *cystathioninuria*. In homocystinuria and cystathioninuria the normal metabolic breakdown of methionine is blocked either at the cystathionine synthetase step or at the cystathionine cleaving enzyme resulting in accumulation and excretion of homocystine and cystathionine respectively. Both these reactions require pyridoxine as co-factor and the higher pyridoxine requirement may be due to structurally changed apoenzymes. Daily doses from 25 to 500 mg of pyridoxine are required to control these conditions. However, in some patients even the high pyridoxine doses show poor or only moderate amelioration of the syndrome, suggesting the presence of an additional, non-pyridoxine dependent metabolic block.

Elevated requirement for *cobalamine* (B_{12}) amounting to 200–1000 mg/day has been reported in some children with metabolic acidosis excreting large amounts of *methylmalonic acid* in their urine. The normal requirement for B_{12} is estimated to be 1 mg/day. These children were found to be deficient in methlymalonyl CoA mutase, an enzyme catalysing the isomerization of methylmalonyl CoA to succinyl CoA and requiring a B_{12} coenzyme as co-factor. Additional studies have revealed a form of this disease which is not responsive even to the high B_{12} doses and probably involves a defective CoA mutase apoenzyme. *Propionicacidemia* is another form of genetic metabolic acidosis which remits following treatment with high doses of *biotin*. The metabolic block is probably located at the biotin-dependent propionyl CoA-carboxylase. Again, in some children, the treatment with biotin is not effective, suggesting an additional metabolic block.

Other instances of genetically determined increased vitamin requirements include the thiamine-responsive form of *maple-syrup* urine-disease, thiamine-responsive form of *megaloblastic anemia*, *nicotinamide*-dependent *Hartnup* disease characterized by *pellagra*-like symptoms and gross *aminoaciduria, familial hypophosphatemic rickets* requiring up to 1000 times the normal dose of vitamin D for proper treatment, and *vitamin K dependent* congenital deficiency of several coagulation factors. This list of vitamin-dependent hereditary diseases is necessarily incomplete. However, it suggests that with increasing knowledge of metabolic pathways, additional forms of such metabolic derangements will become amenable to treatment.

2. "Iatrogenic" vitamin deficiencies

Treatment with some drugs has been reported to lead to the development of vitamin deficiencies requiring additional supplementation of the diet. *Penicillamine* is being used for treatment of the *Wilson's disease* and in certain types of heavy metal intoxication. Its continuous use has been reported to produce *pyridoxine deficiency* due to formation of a penicillamine—pyridoxal-5-phosphate complex. *Isoniazid*—one of the main-stays of tuberculosis therapy—is another preparation causing *pyridoxine* deficiency. It has been suggested that isoniazid combines with the pyridoxal and is excreted in the urine, thus depleting body stores of the vitamin. More recent work indicates, however, that vitamin depletion may not be the main mechanism for the isoniazid anti-vitamin effects. *Cycloserine,* a useful anti-tuberculosis drug, also increases urinary excretion of pyridoxine and produces symptoms of pyridoxine deficiency, which can be prevented by simultaneous administration of large doses of *pyridoxine*. It should be mentioned, however, that some of the side-effects of the treatment with *cycloserine* could not be prevented by the vitamin.

In addition to producing pyridoxine deficiency, *isoniazid* and *cycloserine* have been suspected of leading to *folic acid* deficiency and subsequent development of *megaloblastic anemia*. The possible metabolic processes involved in this action are not known. Megaloblastic anemia has been observed also in certain patients treated with anticonvulsants, such as *hydantoins, barbiturates* or *primidone* or *folic acid* analogs such as *methotrexate*. Treatment with *folinic acid* is suggested. It should be kept in mind, however, that in some cases the vitamin treatment may reverse the therapeutic effect of the drugs producing vitamin deficiency.

3. Other instances of the use of high vitamin doses

High doses of a specific vitamin are sometimes used based on the observation of their beneficial effects but without any definite explanation for the mechanism of their effectiveness. One example of such treatment is the use of large doses of *nicotinic acid* for *treatment of elevated blood lipid levels*. A reduction of free fatty acids has been suggested as a possible explanation for the hypolipemic effect of

nicotinic acid; however, this effect is relatively short-lasting and is frequently followed by a "rebound" rise of the free fatty acids. The exact mechanism of action has not yet been clarified. The use of high doses of nicotinic acid for treatment of *schizophrenia* is controversial and its evaluation will have to wait for the outcome of the presently conducted large scale experiments in Canada. Examples of other uses of vitamins without a clearcut metabolic explanation include the treatment of miscellaneous *neuropathies* with high doses of *cyancobalamine* and of certain types of skin lesion with vitamin *A preparations*.

The recognition of the need for high doses of vitamins should be associated with the awareness that overdose of certain vitamins, especially of A, D, and K, may lead to the development of serious side-effects. □

PATIENT ALERT!

Snowmobilers!

- *Wear protective gear!*
- *Stay on developed snowmobile trails!*
- *Take training before you drive!*

These cautions are true for adults and, especially, for children.

A CASE IN POINT

On the 28th of December at 7:00 p.m (after dark), a 12-year-old girl drove a snowmobile for the first time and without prior training. She wore no goggles, helmet, or snowmobile suit, although all are recommended. After being on the machine only three minutes, the child drove it down the alley behind her backyard and, at 25 mph, proceeded onto a nearby state highway. There the snowmobile struck the rear wheels of a mobile home being towed. As a result the child was hospitalized with a fractured femur, abdominal pain, and lacerations and abrasions on the chin and forehead.

This girl was one of 86 snowmobile victims treated in the emergency room of St. Joseph's Hospital, Marshfield, Wisconsin, during the 1970–1971 season. Almost half (45%) of the victims had less than one year of experience; 37 (43%) of the victims were less than 21 years old; and 61 of the 86 accidents occurred after dark.

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The Journal Editors invite other physicians to submit interesting photographs or brief case reports such as this one to support a continuing effort in providing patients with information that might be helpful in preventing future illness or injury. Physicians are urged to clip and post this report in their reception areas for the benefit of patients.

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Chronic Hemodialysis at Home

The Only Economical Answer to Terminal Renal Patients Awaiting Renal Transplants

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JAMES W. SARGENT, MD
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HEMODIALYSIS RECEIVED ITS initial stimulus from the work of Dr. John Abel in 1912 at Johns Hopkins University School of Medicine and was first made practical in the human by Dr. Wilhelm Kolff in Holland during World War II. Although hemodialysis was brought to this country in 1948 by Drs. Carl Walter and F. D. Murphy, chronic hemodialysis for the maintenance of life was not begun until 1961 when Dr. Belding Scribner in Seattle proved that terminal kidney patients did not have to die. Some of his original patients are still living today on hemodialysis and working five days a week.

Chronic hemodialysis for the maintenance of life was begun in Milwaukee, Wisconsin, in 1965 at St. Michael Hospital. Before this could become financially possible, the training of assistants to the physicians had become paramount, as in 1948 acute hemodialysis required the attendance of

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approximately eight physicians. By 1958 it required the attendance of six physicians, and by 1959 three physicians and one nurse were necessary for the procedure. In 1965 when chronic hemodialysis first was begun in Milwaukee, one nun was trained to run an artificial kidney on a 15-year-old girl at St. Michael Hospital.

Through the experience of transperitoneal dialysis the nun had become accustomed to the idea of dialysis using solutions other than blood that were not likely to harm the patient. Gradually under medical supervision she switched over to the dialyzing of blood through a MacIntosh catheter and finally to the use of an AV shunt in an extremity for the maintenance dialysis of this girl.

Following the success with this girl a male high school graduate was dialyzed at St. Michael Hospital twice weekly until such a time as he received a kidney transplant nine months later. These two were soon followed by others to a total of 95 patients.

The original cost of hemodialysis in a private hospital in 1958 was $1,200 per run. Through the utilization of allied health personnel and nurses in a hospital environment, this cost was cut to approximately $200 per run by 1966. Utilizing a hospital dialysis center, the cost subsequently dropped to approximately $125 per run. When this cost is multiplied three times a week, it amounts to approximately $1,500 per month or $19,500 per year. If dialysis were done only twice weekly, the cost could be cut to $13,000 a year.

Our unit presently believes this cost can be cut even further by chronic dialysis in the patient's home. Because of this we have undertaken the training of a responsible member of the family as well as the patient himself in the techniques of hemodialysis. They thus become an assistant to the physician and following the orders of the physician are able to dialyze themselves at home.

Utilizing home dialysis the actual cost has been reduced to $5,400 per year or approximately $35 per run. At the present time utilizing more streamlined techniques of coil-saving, this cost may be cut further to $15 per run reducing the overall cost of dialysis to under $2,400 per year.

Such cost reductions plus improved techniques enable patients dying of chronic renal disease to continue life in a normal fashion with the slight variation of being hooked up to an artificial kidney and dialyzed at home by their spouses and themselves.

To date St. Michael Hospital has graduated 108 allied health people from its Hemodialysis School. These people may be divided into three categories, and they have been trained in the following manner:

The physician. A physician is considered a nephrologist if he is active in the hemodialysis department and takes care of kidney patients for approximately two years beyond his normal training. Other physicians are needed to maintain satellite centers in areas removed from the hemodialysis center. A hemodialysis satellite physician is required to spend several weeks in a dialysis unit and then run an artificial kidney on several patients in a hemodialysis center for four months, at which time he is classified as a satellite hemodialysis physician. Other physicians may qualify for supervising patients already on home dialysis with a minimum of further experience.

In our efforts to train physicians for these categories it became evident that it was difficult to free a physician for a time long enough to fulfill all the necessary requirements in certain cases. For this reason it became necessary to train allied health people as assistants to the physicians.

The nurse. The director of a hemodialysis center or satellite is required to be a graduate nurse. She is required to complete the two-month training course in hemodialysis as given by the School, to spend approximately two months as an active member of a dialysis unit, and to be responsible under the nephrologist for the care and dialysis of center patients during the last month of her presence in the unit.

The technician. A hemodialysis technician is required to work in a hemodialysis unit for approximately two months, five days a week. He learns to run the artificial kidney on multiple patients under the direction of the physicians and nurses and is capable of running the patient alone in a hemodialysis home situation. This particular individual is classified as a hemodialysis tech-

nician and is able to assist physicians in the dialysis of patients in satellites under a hemodialysis nurse. Hemodialysis technicians of a lesser category are the spouse and the dialysis patient himself. Such persons study for approximately two months and learn to dialyze their own loved one along with the person being dialyzed. They are not taught to dialyze any person other than their own family member. Should they desire to become dialysis technicians, they would have to return for one month more of training to be eligible. These people are taught to keep records, sterilize and prepare the machines, and to put the patient on and take him off the unit.
They must be so well trained that the physician will feel secure in having them take care of their own loved ones at home as far as 500 miles away from the center. Of course a physician, their own doctor preferably, is on call in case any emergency such as a clotted shunt or a mechanical failure should arise. Most of these situations can be handled by the technician and are corrected before a phone call is made to the physician in charge of the dialysis center.

In summary, the utilization of assistants to physicians and allied health personnel in the form of graduate nurses, hemodialysis technicians, and family members has enabled the nephrologist to deliver medical care in the form of hemodialysis to patients who ordinarily would die of kidney disease. This procedure has been refined and established to a point where it is now being done at a cost that can be borne by health insurance companies and tax-supported programs such as Title 19 (Medicaid), and in the future possibly by the patient himself without insurance. As further refinements develop the cost will be proportionally lowered.

The training of allied health personnel takes place in a community hospital over a one- to three-month period. To date the hemodialysis center at St. Michael Hospital has provided approximately 100 years of additional life to otherwise hopeless patients and has taken care of some 95 different patients over the past five-year period.

Only through the utilization of allied health personnel and assistants to physicians could such a thing be possible. □

Biochemical Studies on a Variant of Branched Chain Ketoaciduria in a 19-Year-Old Female

M H FISCHER, PhD and THEO GERRITSEN, DSc, Central Wisconsin Colony and University of Wisconsin Medical Center, Madison, Wis: *Pediatrics* 48:795–801 (Nov) 1971

Branched chain ketoaciduria (BCKA), or maple syrup urine disease, is a rare, serious, usually early fatal disease found in newborn infants. The primary deficiency of this inborn error of metabolism exists in the enzyme(s) mediating the oxidating decarboxylation of the ketoacids derived from leucine, isoleucine, and valine. Large amounts of these ketoacids and amino acids are excreted in the urine. The finding of 233 mg of branched chain ketoacids in the urine of a 19-year-old female was therefore surprising. The patient was physically in good health and had a full scale IQ of 76. The excretion of branched chain amino acids and keto acids could be increased by feeding a diet high in protein. The branched chain ketoacid decarboxylase activities in the peripheral leukocytes and in skin fibroblasts were found to be decreased to only a very small fraction of control values and were comparable to the levels found in a case of classic BCKA. □

Personality (MMPI) and Cognitive (WAIS) Changes After Levodopa Treatment

J V BEARDSLEY, PhD, Gundersen Clinic Ltd, La Crosse, Wis: and F PULETTI, MD, University Hospitals, Madison, Wis: *Arch Neurol* 25:145–150 (Aug) 1971

A group of patients receiving levodopa was given psychometric (Wechsler Adult Intelligence Scale) and personality (Minnesota Multiphasic Personality Inventory [MMPI]) measures at one and six months, and then were compared with a control group who had received traditional treatment (anticholinergic drugs and/or thalamotomies) over a similar time period. Generally, on the Wechsler intelligence quotients test patient performances on the control group declined, and performances on the levodopa group improved. Practical and statistically significant group differences were obtained on verbal (9.6 IQ points), performance (7.7), and full scale (9.0) IQs at six months. No consistent group differences over the six-month period were obtained on the MMPI, but the typical elevation of scale 3 (depression) found on neurologically impaired patients occurred. □

Calcium Levels Lowered

An intravenous bolus injection of mithramycin (25 mcg/kg body weight) given to patients with malignancy-related hypercalcemia produced a gradual but steady decrease in serum calcium, according to a group of researchers led by Dr. R. E. Slayton of Presbyterian–St. Luke's Hospital, Chicago.—AMERICAN DRUGGIST, Jan. 24, 1972 □

Double Rupture of the Heart

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Madison, Wisconsin

CARDIAC RUPTURE is a complication that occurs in 5% to 10% of all patients dying in the acute stage of a myocardial infarction. There are several case reports and reviews of this subject in the literature, some of them quite recent.[1-5] Double rupture of the heart, that is, rupture of the interventricular septum as well as the ventricular wall, has been only rarely reported.[4]

A patient was recently seen with this rare complication.

Case Report

An 80-year-old man, a retired federal employee, was brought to the hospital and died less than 12 hours later. His neighbors brought him in because he "didn't look good." He was unable to give a history. His companions stated that he had been ill for about six days, had complained of chest pain at the onset, and had a decreased oral intake during that period. He had refused hospitalization at the onset because he was taking care of his invalid wife at home.

In the emergency room his blood pressure was unobtainable, pulse 90, and he was noticeably dehydrated. There were only 5 ml of urine in his bladder. Dextrose 5% in water was started intravenously, and 90 minutes later on the medical ward his blood pressure was 80 systolic, pulse 96, respirations 25, and temperature 97 F. He appeared chronically ill and was confused. His neck veins were distended at a 90-degree angle. He had a decreased inspiratory effort. There were rhonchi throughout the lung fields and a few rales at the bases. The left cardiac border was 2 cm to the left of the mid-clavicular line. There was a left ventricular heave and a thrill at the left sternal border. The heart tones were not remarkable. There was a grade IV holosystolic murmur at the left third to fourth intercostal space radiating to the base of the neck. A "scratchy

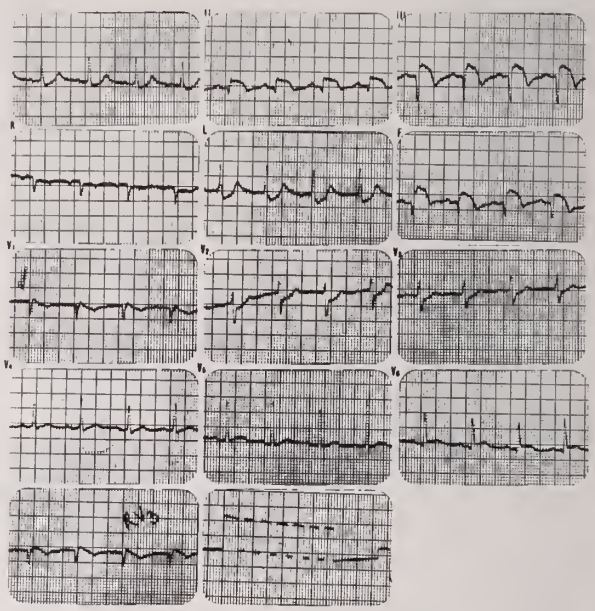

Figure 1—Electrocardiogram on admission showing acute inferior wall myocardial infarction.

Figure 2—Bedside chest x-ray film on admission.

From Madison General Hospital. Doctor Crocker is an Internist and Assistant Clinical Professor of Medicine, University of Wisconsin Medical Center. Doctor Storms is a Captain, Medical Corps U. S. Army, and is a former Resident in Medicine, University of Wisconsin Hospitals. Doctor Lamphere is a Resident in Pathology, Madison General Hospital.

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Figure 3—Probe passing behind the papillary muscle, through the ventricular septum, and posteriorly through the right ventricular wall.

sound" was described in early and late diastole. There was no liver enlargement, and there was a trace of edema of the legs.

An electrocardiogram showed a sinus tachycardia, rate 95–105. There was a Q in leads II, III, and aVF with S–T segment depression in the anterior leads (Fig 1). The clinical impression was of an inferior wall myocardial infarction with either a ruptured septum or papillary muscle. The lack of more severe left heart failure was confusing. The chest x-ray films confirmed the lack of pulmonary congestion, showing only moderate cardiac enlargement, mostly left ventricular, and some blunting of the costophrenic angles (Fig 2). The urinalysis showed a 4+ albumin and heavy bacteria, but the culture was negative at 24 hours. Blood sugar was 170 mg/100 ml. A complete blood count was unremarkable except for a white cell count of 19,000. He was treated with digoxin, furosemide, meperidine, and oxygen. There was no urinary output. Seven hundred milliliters of blood were removed rapidly by phlebotomy. Nine hours after admission his pulse rate was 96, respirations 32, and of Cheyne–Stokes quality, and blood pressure 80/60 mm Hg. He died after another two hours.

Postmortem findings: The pericardial sac contained 250 ml of clotted blood. The pulmonary artery and its main branches were free of emboli. The heart weighed 490 gm. The posterior lateral surface of the heart near the base was hemorrhagic, very soft in consistency, and yellowish-tan to deep reddish-brown. The various cardiac valve leaflets were thin and pliable and the chordae tendinae were normal. The coronary ostia were patent. The right coronary artery was completely occluded by thrombotic material 1.5 cm distal to its origin. The circumflex branch of the left coronary artery was narrowed to a small opening by atheromatous material.

On cut section the posterior portion of the right ventricle and the entire left ventricular wall on the posterior surface was necrotic, dark reddish-brown to yellowish-tan, and soft in consistency. In the posterior wall of the left ventricle just behind the posterior papillary muscle, the myocardium was necrotic, very soft in consistency, hemorrhagic, and contained areas of clotted blood. The necrotic and hemorrhagic changes extended through the entire thickness of the posterior wall of the left ventricle to the pericardial surface. In the same area the posterior portion of the interventricular septum was ruptured for a diameter of 2.3 x 1.5 cm (Figs 3 and 4). The left ventricle varied from 1 to 1.8 cm in thickness.

Figure 4—Hemorrhagic area of the posterior wall of the right ventricle including rupture, and probe passing through ventricular septal rupture.

Discussion

The various anatomic sites of cardiac rupture can be classified as to frequency of occurrence and clinical features: The most common type of heart rupture accounting for nearly 90% of cases is a transmural one with hemopericardium and often an immediate death from cardiac tamponade. Interventricular septal rupture is more unusual, accounting for about 12% of all cardiac ruptures. This is usually a dramatic event leading to cardiac failure, shock, or both, but on occasion it may respond to medical treatment.[3] Surgical repair of this type of perforation has been undertaken without encouraging results.[5] The most unusual single rupture is the rupture of a papillary muscle, often the posterior one. In one series this represented only 0.9% of the 578 patients with myocardial infarction studied at postmortem.[3] Mitral insufficiency resulting from this kind of rupture usually gives rise to left heart failure and pulmonary edema. The murmurs caused by septal rupture and papillary muscle rupture are similar, and are not helpful in distinguishing between the two lesions. The differential diagnosis between the two lesions can be made with certainty only by

TABLE 1—*Clinical and Pathologic Findings*

Case	Sex	Age	BP	Clinical Diagnosis	ECG	Murmur	Time Interval Infarction to Death	Location & Size of Ruptures
1. Snyder[6] (1940)	M	60	.....	Congestive failure	Not recorded	Not recorded	2 days	Septum 12x8 mm & post. wall L. ventricle 2.2 cm
2. Carroll[7] (1947)	M	60	105/90	Post. myocardial infarction	Post. wall myocardial infarction	Systolic apical	7 days	Base of septum 3x1.5 cm & post. L. ventricle 4x1.5 cm
3. Gottsegen[8] (1957)	F	74	120	Post. wall myocardial infarction	Post. wall myocardial infarction	Holosystolic precordial	5 days	Septum 1 cm & post. wall R. ventricle 1.5 cm
4. Swithinbank[9] (1959)	F	85	.....	Dead at home	.....	.....	Unknown	Lower septum post. wall R. ventricle
5. Sanders[10] (1956)	F	72	.....	Myocardial infarction	Lateral wall acute myocardial infarction	None	Perforation to death few hours	Septum 2.5 cm & ant. wall L. ventricle 1 cm
6. Sanders[10] (1956)	F	76	.....	Myocardial infarction	Acute post. wall myocardial infarction	None	Perforation to death 2 hours	Septum 3.5 cm & post. wall R. ventricle
7. Kawakami[11] (1965)	M	68	166/98	Spinal subdural tumor sudden death	Normal	None	Unknown	Septum & ant. LV wall
8. Sugiura[4] (1970)	F	70	210/130	Myocardial infarction	Old ECG RBBB, no acute ECG	None	1 day	Septum 1x0.7 cm & ant. wall R. ventricle 1 cm
9. Crocker (1972)	M	80	90/	Myocardial infarction septal rupture	Acute post. wall myocardial infarction	Grade IV holosystolic 3-4 ICS L. of sternum	Probably 6 days	2.3x1.5 cm septum & post. wall

cardiac catheterization. In addition to being less common, a papillary muscle rupture is more likely to lead to death within the first day.[5]

Cardiac rupture is age related, occurring more frequently past 80 years than before 50, and is more common in the female, and in persons with hypertension.[3] In a clinicopathologic study by Sugiura, both old and fresh myocardial infarctions were found, with the junctional area between the fresh myocardial infarction and the scar being the predilected site of rupture.[4] As has been stated, double cardiac rupture is extremely rare. It has been the subject of a recent review by Sugiura and Okada. They reviewed 79 autopsy cases of myocardial infarction, and found 11 cases with myocardial rupture, only one of them being a double rupture. In their case there was an anteroseptal myocardial infarction with first a septal perforation, then right ventricular rupture. They found 7 similar cases of double rupture in the literature, in which 5 showed a combination of septal perforation with a rupture of the right ventricle and ventricular septum.[4] These cases were reviewed and along with the current case are the subject of Table 1. Of the seven previous cases examined antemortem, only two had murmurs recorded. This is hard to understand. The ventricular wall which ruptured along with the septum was the anterior left in two, posterior left in three, anterior right in one, and posterior right in two.

A review was made of the occurrence of myocardial rupture at Madison General Hospital for the years 1957 through 1969. The purpose of this review was to see how the experience in a community general hospital of 475 beds compares with the published series. From 1957 through 1964 the medical records coded "rupture of the heart due to infarction" were reviewed. In 1965 the hospital adopted the International Classification of Diseases in which there is no separate code number for heart rupture. For the period of 1965 through 1969 all the autopsy proven cases of myocardial infarction were personally reviewed by one of the authors. From 1957 through 1964 five cases of rupture of the left ventricular wall were found, occurring in four males age 51 through 83 and one female age 54. From 1965 through 1969, 104 autopsy proven cases of myocardial infarction were reviewed. There were 70 men and 34 women in this group. The ages ranged from 38 to 93 with a median age of 70. In this group there were 15 myocardial ruptures in 12 men and 3 women age 38 to 80 with a median age of 70. Of the 104 infarctions, 28 were posterior wall; 4 were "massive" or anterior and posterior; 70 were anterior, anteroseptal or anterolateral; and 2 were infarctions of the right ventricle. Of the whole group of 20 cardiac ruptures from 1957 through 1969, there were no papillary muscle ruptures; there were 3 ventricular septal ruptures, 2 occurring in poste-

rior wall infarctions, and one in an anterior wall infarction, and 17 ventricular wall ruptures with tamponade; 10 of them anterior wall, 7 of them posterior wall. In this group the previously reported predominance of women was not noted.[3] There were only three patients 80 years or over and there were seven between the ages of 51 and 59.

Conclusion

A case of double rupture of the heart is reported, and placed in its setting of myocardial infarction and rupture in a community hospital. The general topic of myocardial rupture is reviewed, and clinical and statistical information is presented related to the antemortem diagnosis. The previously reported eight cases of double rupture of the heart are reviewed and compared with the present case.

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Asthmatic Children Aided

Cronolyn sodium given to a group of chronic asthmatic children over a 12-month period enabled a majority of the patients to reduce or discontinue the use of oral bronchodilators and adrenal corticosteroids, say Drs. J. S. Hyde and C. Swarts of Rush Medical Center, Chicago.—AMERICAN DRUGGIST, Jan. 24, 1972 □

Chemosurgery for Facial Neoplasms

F E MOHS, MD, University Hospitals, Madison, Wis: *Arch Otolaryngol* 95:62–67 (Jan) 1972

The complete microscopic control of excision which characterizes chemosurgery is of particular value in the treatment of malignant facial neoplasms because these lesions often send out slender strands and thin sheets of cancer cells for a considerable distance beyond the clinically apparent borders of the tumor mass. These unpredictable outgrowths are selectively followed to their terminations by excising the cancers layer by layer with microscopic scanning of each layer through the systematic use of frozen sections. To facilitate the removal of form-retaining layers, the tissues usually are chemically fixed in situ prior to excision by means of zinc chloride, but in some instances, notably eyelid margin cancers, the preliminary fixation is omitted and frozen sections of fresh tissue specimens are used to achieve the complete microscopic control.

The microscopic control obviates the need to sacrifice a wide extra margin of normal tissues and at the same time provides unprecedented assurance of complete eradication. For example, the five-year cure rate in a series of 7,432 cases of basal cell carcinoma of the skin treated chemosurgically was 99.2% as compared to the averages compiled from the literature of 95.5% for cold knife surgery, 92.6% for electrodesiccation and curettage, and 94.7% for radiation therapy. Correspondingly high cure rates also were achieved by the chemosurgical excision of squamous cell carcinoma of the skin (93.2% in a series of 2,251 cases) and of squamous cell carcinoma of the lips (93.1% in a series of 1,060 cases).

Though simple in concept, the chemosurgical technique is more complicated in practice, so training in its use is needed for optimal results. Eventually, trained professional and technical personnel and adequate facilities for chemosurgery should be available in every large population center. □

Pain Relief Rated

Clonixin, a nicotinic acid derivative, when given in an oral dose of 600 mg, provides pain relief equal to 100 mg morphine sulfate given parenterally, Drs. J. S. Finch and T. J. DeKornfeld of Plymouth, Mich., report in the *Journal of Clinical Pharmacology*.—AMERICAN DRUGGIST, Jan. 24, 1972 □

Silver Nitrate for Burns

A 0.5% topical silver nitrate solution lowered the mortality rate significantly among aged patients with burns over less than 30% of their bodies, according to Dr. C. E. Hartford of University Hospital, Iowa City, Iowa.—AMERICAN DRUGGIST, Jan. 24, 1972 □

An Overview of Chronic Recurring Headache

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FEW DISORDERS have generated as many theories concerning etiology as has headache, and as yet we still do not fully understand all its facets. Most of the basic and clinical investigations have been confined to one type, migraine, and these will be reviewed here with special reference to pathogenesis and present clinical concepts in the diagnosis and differential diagnosis of migraine and of other types of chronic recurring headache. In addition, the present status of the treatment of chronic recurring headache will be discussed.

Pathogenesis

The exact site of origin of a migraine attack remains unknown as yet. Major attention has been directed toward the peripheral nervous system, but there is increasing acceptance of the view that the central nervous system plays an important part. Present evidence holds that the symptoms of migraine are related to a disturbance of the central vasomotor centers, the extra- and intracranial blood vessels, and the microcirculation.[1,2] Each attack represents a phase of arterial vasoconstriction, largely intracranial, and a phase of arterial vasodilatation coming from extracranial or scalp arteries. In addition, a "sterile inflammation" of the arterial wall exists which may depend upon the local accumulation of pain-producing substances. The focal neurological symptoms of migraine are probably initiated by intracranial vasoconstriction, associated with a secondary process of spreading cortical depression to account for the slow progressive march of neurological symptoms.

The possibility that defective humoral control of cranial vessels is a factor in the genesis of migraine has been proposed of late. Sicuteri[3] states that pain receptors are stimulated biochemically at the time of the migraine attack and that at least three events take place: (1) with vasoconstriction there is local release of catecholamines and increased urinary excretion of vanilmandelic acid; (2) when the vessels dilate, serotonin is released from mast cells and sensitizes the "cranial nociceptors;" (3) bradykinin is released from an inactive alpha 2 globulin precursor, kininogen, by proteolytic enzymes in the blood. The pain-provoking action of bradykinin is potentiated by serotinin, and a local accumulation of these and allied substances may play a part in vascular pain. It should be noted, however, that the intradermal injection of bradykinin does not cause vascular headache in man.

Lance[4] and his coworkers report that plasma serotonin measured as micrograms per 10^9 platelets falls sharply at the onset of an attack, and the urinary excretion of 5-hydroxyindoleacetic acid increases. The plasma serotonin remains lower than normal for the duration of the attack. They suggest that the decrease in plasma serotonin is apparently specific for the migraine attack and not merely a reaction to stress or to the onset of the headache. Serotonin changes are caused by the presence of a serotonin-releasing factor in the plasma during migraine and not due to any alteration in the serotonin-binding capacity of platelets. The resultant lowering of plasma serotonin content initiates the vascular changes responsible for migraine headache. Since serotonin constricts scalp arteries in man, a fall in plasma serotonin may account for the extracranial vasodilatation associated with the migraine attack. However, there is as yet no satisfactory explanation of unilateral headache within the serotonin theory.

Utilizing enzyme histochemical techniques (fluorescence methods), Adams[5] and his coworkers have suggested that the tunica adventitia around migrainous arteries has an abnormal capacity to bind norepinephrine. This binding may prevent norepinephrine from acting on the smooth muscle fibers in the medial coat of the dilated artery. Histological and histochemical examinations of temporal artery

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biopsies which they conducted in six patients during a migraine attack yielded no structural changes or evidence of vascular inflammation.

Thonnard–Neumann[6] has postulated that basophilic leukocytes participate in the migraine process through the action of the heparin contents of their storage granules. At the site of the headache, basophil degranulation occurs first with the release of histamine and then heparin.

Neuropharmacological and biochemical data accumulated to date provide only a partial understanding of events involved in migraine at the humoral level. Recent evidence suggests that in the mechanism of migraine at least three biochemical key factors may be operative: serotonin, norepinephrine, and bradykinin. No convincing evidence implicates acetylcholine or histamine in the mechanism of migraine.

Participation of the sympathetic nervous system in the migraine attack is questionable even though capillary dilator fibers via the sympathetics are distributed to the vessels of the scalp and forehead. The consensus at the present time is that the sympathetic nervous system exercises only a weak, inconsistent tonic effect on the intracerebral vessels and plays very little role in maintaining tonic constriction of scalp vessels. Sharply defined neurological symptoms usually constitute the prodromata of classic migraine. These are usually visual, sensory, or motor, and generally unilateral. These preliminary manifestations are caused by ischemia associated with constriction of certain cranial arteries. The fact that these prodromata may be produced by intravenous infusion of norepinephrine and occasionally aborted by amyl nitrite or carbon dioxide, are cited to endorse the vasoconstrictor hypothesis.[7]

Further support is derived from cerebral blood flow studies utilizing inhalation of radioactive xenon which show that the cortical perfusion rate diminishes within the first two hours of migraine headache. Cerebral angiograms taken while a patient had scotomata show decreased filling of the branches in the internal carotid artery with reflux into the vertebral system. On the other hand, films taken both immediately before and after the visual disturbance revealed normal filling of the branches of the internal carotid artery.[8]

The slow evolution of the visual phenomena in the migraine attack suggests that the cortical depression is preceded by a cortical excitation. Lashley[9] and others plotted the expansion of their own visual scotomata in migraine and calculated that the visual cortex was being suppressed at the rate of 3 mm each minute. This is the same rate of progress as the spreading depression which interferes with cortical recordings in animal experiments.

The precise interpretation of electroencephalographic (EEG) abnormalities during an attack is still to be determined.[10] While these abnormalities are more frequent in patients with migraine than in a comparable control population, the difference is not of diagnostic significance. During an attack, the EEG usually does not change except for a slowing of rhythm in the affected occipital lobe during a visual prodrome. However, other focal abnormalities are frequently found in patients with neurological deficits associated with their migraine.

All-night EEG recordings were obtained in eight of our patients with nocturnal migraine.[11] The onset of the headache was related to the REM (rapid eye movement) stage of sleep. When the sleep–wake cycle was phase-shifted, the sleep headache attacks also shifted and maintained their temporal relationship to the REM sleep stage.

Heyck[12] observed that the temporal veins and arteries were prominent during a migraine attack and that the venous blood coming from this area was red. The arteriovenous oxygen ratio on the headache side of the head was below normal. He suggested that arteriovenous shunting occurred with arterialization of the venous blood. It is possible that the opening of arteriovenous shunts in the brain may also play a role in the pathogenesis of migraine.

Studies in our laboratory of cutaneous blood flow in the frontotemporal area of the head by NA^{24} clearance, provide an index of the blood flow of the tissues under investigation.[13] During a migraine attack, the blood flow was increased; the flow on the headache side of the head being greater than the contralateral side; there was no increase in forearm flow. Norepinephrine and ergotamine, vasoconstrictors, effectively relieved the headache while reducing local tissue blood flow. We concluded that the increased tissue blood flow during migraine was intimately related to the pain.

We have applied a relatively new technique, thermography, to the study of migraine.[14] This provides a two-dimensional photograph of the radiant heat emitted from the body. Thermographic changes in a high percentage of patients with migraine studied recently constituted objective evidence that a related vascular change was present. In the migraine patient, skin cooling shown thermographically was in the area of the forehead which is supplied by the external carotid artery. In some cases this appeared as a broad band of higher temperature. In cluster headache, a small very cold insular area is observed in the region supplied by the internal carotid artery. Occasionally the pattern resembles that of carotid stenosis. These thermographic changes found during an attack reverted to normal when the patient became asymptomatic.

Diagnosis

The clinical evaluation of a patient with headache often will require no more than a history to indicate the probable diagnosis. If the initial interview is detailed and comprehensive, the majority of patients can be assessed adequately without recourse to special investigations. Physical and neurological

examinations and psychological evaluation should be part of the total evaluation.

A clinical classification of the many varieties of headache that has proved to be most useful was that published by the Ad Hoc Committee on Headache of the National Institute of Neurological Diseases and Blindness.[15] This was based on knowledge of pain mechanisms.

In general, vascular headaches of the migraine type are recurrent attacks of pain in the head, commonly unilateral in onset, usually associated with anorexia and sometimes with nausea and vomiting.

In some patients, they are preceded by or associated with sensory, motor, and mood disturbances. They are often familial.

In classic migraine, the prodromes usually are sharply defined contralateral neurological manifestations of a visual, sensory or motor nature, or combinations of these.

In common migraine, the prodromes are not sharply defined and may precede the attack by several hours or days. They include psychic disturbances, gastrointestinal manifestations, and changes in fluid balance. The actual head pain is frequently of longer duration than in the classic type. It may last from many hours to days.

In cluster migraine, prodromes are uncommon and associated symptoms are localized to the cervical sympathetics. Cluster headache occurs in a series of closely spaced attacks which may be followed by remissions of months or even years.

Two types of migraine, hemiplegic and ophthalmoplegic migraine occur rarely and generally in the young adult. The pain is moderate, and the ophthalmoplegia or hemiplegia outlasts the headache by hours or even days. Another type of migraine called basilar artery migraine has been described by Bickerstaff.[16] Its prodromal symptoms include visual loss and a variety of brain stem symptoms including vertigo, ataxia, dysarthria, and paresthesias, followed by severe, throbbing, occipital headaches with vomiting. This type of migraine occurs in girls and young women and often has a striking relationship to menstruation.

In some cases, migraine attacks may be replaced by the periodic recurrence of some other bodily disturbances called "migraine equivalents." These may consist of abdominal pain associated with nausea, vomiting, and diarrhea (abdominal migraine); pain localized in the thorax, pelvis, or extremities; bouts of fever; attacks of tachycardia; benign paroxysmal vertigo, and cyclical edema. Psychic disturbances including confusion, lethargy, disorders of mood and sleep, behavior, and the like, have been suggested as psychic equivalents of migraine.

Recent arteriographic studies, which excluded the presence of malformations, have indicated that permanent damage of neurologic structures may be associated with migraine. This brings to mind the observations by Charcot[17] that the transient neurologic disturbances of migraine could become permanent. Lesions of the retina, cerebral hemispheres, and brain stem have been found in patients with migraine. The ages of these patients were below the usual age of onset of cerebrovascular disease. The area most frequently affected is the occipital cortex, and a permanent hemianopsia may occur.

Other conditions which simulate migraine headaches include vascular malformations (angioma), aneurysm, intracranial tumors situated in the occipital lobe of the brain, and hypertension. Head pain from temporal arteritis, carotid and basilar insufficiency, and glaucoma must be considered in the differential diagnosis of older patients. Migraine appears to be independent of the presence or absence of aneurysm or angioma.

The headache that continues for weeks or months should not be readily accepted as migraine.[18] Its long persistence suggests that it may be caused by underlying anxiety and depression.

Headache occurring in patients with mild hypertension has no specific diagnostic features and is usually either migraine or muscle-contraction (tension) headache, as in the normotensive. However, in severe hyptertension, frequent and severe headache is common. This headache is usually occipital, but it may occur elsewhere in the head. It is present on awakening and usually diminishes or disappears several hours later. In the majority of patients, a relationship exists between the intensity of the headache and the degree of hypertension, so that reduction of blood pressure is attended by a reduction in the frequency and severity of headache. While patients with migraine frequently develop hypertension in the later years of life, it is difficult to assess this alleged relationship with any degree of accuracy since migraine is not always clearly defined in these studies. Paroxysmal headache of pulsatile quality, severe tachycardia, pallor, nausea, and vomiting may suggest the possible diagnosis of pheochromocytoma. Appropriate pharmacological and chemical tests, including urinary assay for catecholamines and their methoxy-derivatives should be employed to confirm the diagnosis.

Muscle-contraction headache, also referred to as tension, psychogenic or nervous headache, is probably the most common type of chronic recurring headache extant. The clinical picture for this type(s) of headache includes the following: It is not ushered in by prodromes, it is usually bilateral, with

the majority of patients locating their discomfort in the back of the head and neck. However, the occipital, parietal, frontal regions and face, or all these areas, may be involved in any combination. The headache may cover the head like a cap and it may be accompanied by anxiety and dizziness. Patients describe their symptoms as a sensation of tightness, squeezing, pressing, crawling sensation, as though their head was in a vise. These headaches are non-pulsatile and in contrast to migraine, there is no familial history. They may vary widely in intensity and frequency. The duration of the pain varies from a few hours to days, weeks, or months.

Examination may reveal sustained muscle contraction, areas of local tenderness or nodules in the occipital area, which when pressed may cause pain to spread to other areas of the head. Limited excursion in movement of the neck may be demonstrated in some patients. Muscle-contraction headache is not accompanied by neurologic signs.

In some patients with both cervical disc disease and head pain, the latter may be relieved by surgical procedures on the cervical spine but the relationship is still unclear. Such headaches are almost never part of the acute cervical disc syndrome. Cervical disc disease is a common roentgenographic feature in persons over fifty and is often asymptomatic.

Treatment

The single most important factor in the treatment of headache is consideration of the whole patient, not the symptom. The current treatment of headache is in part empiric and in part based on our knowledge of the underlying mechanisms that produce the symptoms. The importance of psychological influences can be deduced from the periods of remission and of greatly increased activity, response to a variety of treatments for short periods of time, often efficacious effect of placebo therapy, and the success of a physician in whom the patient has confidence.

A critical review of our own investigation and of others concerning the pharmacological treatment of headache indicates that with few exceptions, the conclusions of our 1956 study of 5,000 patients with chronic headache are still valid.[19] We found that the results of drug prophylaxis were remarkably similar irrespective of the agent used, and that only a few drugs were more effective than a placebo.

Migraine

Management of migraine is centered about two aspects of treatment, the acute attack to provide symptomatic relief and interval treatment between attacks to reduce their frequency and severity.

Treatment of an Acute Attack

Ergotamine tartrate is still the drug of choice for the migraine attack, a judgment that few would dispute. The pharmacological effects of ergotamine will vary widely from person to person, and even in one individual, different physiologic states can cause differing responses. The beneficial effect of ergotamine tartrate is probably related to its vasoconstrictive action on the smooth muscles of the cranial blood vessels. Berde[20] recently reported studies on dogs which showed that the nature of the direct vascular effect of ergot compounds was apparently strongly dependent on the preexisting vascular resistance, and that they inhibited the re-uptake of neuronally liberated norepinephrine into storage sites. This effect varied from compound to compound, but was independent of alpha-adrenergic blocking activity.

The synergism obtained by combining caffeine with ergotamine tartrate reduces the amount of the latter required for abortion or attenuation of the migraine attack. Such a combination may be administered by the oral or rectal routes. Antispasmodics and antiemetics decrease the possible gastrointestinal side effects of ergotamine and help to control nausea and vomiting. Though most compound formulations are to be deprecated, there are certain exceptions to every rule, and these combinations seem to have certain virtues. The importance of administering medication early in the course of an attack and in adequate doses cannot be overemphasized.

Frequent attacks of migraine necessitating a frequency of such treatment in excess of that recommended may lead to habituation to ergotamine and the possibility of a rebound reaction of constriction, dilatation, and headache. In our experience, a number of patients who have been taking from 2 to 3 mg of ergotamine daily for three to thirty years complain of daily headaches and require an escalated dosage to secure continued relief. Dependency on ergotamine accompanied by manifestations of withdrawal is another possible complication. It is important to recognize patients who present with such symptoms as increasing frequency of headaches, loss of feeling of well-being, fatigue, and depression. These patients report the occurrence of headache without the medication, but a careful investigation reveals that the use of ergotamine bears little relation to the relief of their headaches. Although most of these patients wear the mask of migraine, they suffer from an underlying depression.[21] The basis of proper treatment is gradual withdrawal of the drug and management of the underlying depression.

Prophylaxis or Interval Treatment

Interval treatment includes all attempts to reduce the frequency and severity of headaches that tend to recur. A few of the drugs suggested for migraine prophylaxis are listed in Table 1.

Methysergide maleate (Sansert®) has proven to be the most useful prophylactic agent in migraine.[22] Just

TABLE I—*Patient Response*

METHYSERGIDE (Sansert®)	60% ±5
BELLERGAL (Phenobarbital, Bellafoline, Ergotamine Tartrate) CYPROHEPTADINE TRANQUILIZERS (Major, Minor) ANTIHISTAMINES ANTIDEPRESSANTS (Tricyclic Compounds, Monoamine Oxidase Inhibitors)	40% +5
DILANTIN® (Diphenylhydantoin) DIURETICS HISTAMINE HORMONES (Gonadotrophins, Progesterones) INDOMETHACIN	40% −5
PLACEBO	40% ±5

USE LIMITED TO 14 DAYS: Ergotamine Tartrate, Cafergot PB and the like, Cortisone.

how it prevents the occurrence of an attack of migraine has not been fully established.[23] Serotonin shares with methysergide the property of potentiating the vasoconstrictor effect of norepinephrine. Serotonin or its precursor, 5-hydroxytryptophan, inhibits various pressor and depressor reflexes in the experimental animals. Methysergide has a similar although weaker effect in man. Thus it may simulate the action of serotonin and so act as a competitive antagonist by occupying the same receptor sites or blood vessels. Its beneficial action in migraine may be due to preserving tonic vasoconstriction of scalp arteries as the plasma serotonin drops during a migraine attack. A consequence may be to arrest the vasodilatation or pain phase of the migraine attack.

Regular administration of 2 to 6 mg daily of methysergide will suppress recurrent attacks of migraine completely or in part in approximately 60% of patients with migraine. However, 20% to 40% of patients experience such adverse side effects as abdominal discomfort, muscle cramps, and in some instances swelling, depression, numbness, tingling of extremities, and the like. Of this group, about 10% are unable to tolerate methysergide because of symptoms of peripheral vasoconstriction or—rarely—angina pectoris. These symptoms disappear when medication is stopped.

Besides the early known side effects, a syndrome resembling retroperitoneal fibrosis or pulmonary fibrosis occasionally develops during long-term therapy with methysergide.[24] This syndrome can develop silently in patients, as reported in our study in 1963. We performed intravenous urography in 114 consecutive patients who had been taking methysergide for periods of three months to six years with no clinical or laboratory symptoms of retroperitoneal fibrosis.[25] Three of these patients had abnormal characteristics in their urograms which were diagnostic of retroperitoneal fibrosis. It is usually not hazardous if used cautiously, and therapy is interrupted for eight weeks at six-month intervals. Methysergide is certainly the most effective prophylactic preparation for the control of migraine. It should be noted that it is not effective or intended for the treatment of the acute attack of migraine. In general, the daily use of ergotamine for migraine prophylaxis is not advisable. However, for patients suffering from nocturnal attacks of cluster headache, an oral dose of 1 to 2 mg before retiring, taken for a period of ten to fourteen days, may help to terminate the series of headaches.

A potent serotonin and histamine antagonist, cyproheptadine hydrochloride (Periactin®), has also been employed as a prophylactic treatment for migraine. We have studied this drug over the past few years in a double-blind controlled design and have not found it to be significantly different than other agents which are available, such as bellergal. The side effect of increased sleepiness was quite pronounced in many of our patients.

Similar in action to cyproheptadine is B.C. 105, a tricyclic derivative, which has undergone evaluation for the prophylaxis of migraine. The reports on this agent are conflicting, and the studies short-term, but it is evident that it is not as effective as Sansert® but more so than placebo.

There have been numerous reports over the past forty years of the beneficial effects of hormone preparations in the prophylaxis of migraine. The advent of the oral contraceptives set off a new wave of interest in the use of hormones in the treatment of migraine. However, the administration of contraceptive pills tends to exacerbate the condition in many women rather than improve or reduce the frequency of migraine attacks. A double-blind cross-over study with an oral progestagen preparation (demigran) which we conducted failed to show that it was more efficacious in preventing migraine than a placebo.

Anthony and Lance[26] recently reported on a two-year study with phenelzine, a monoamine oxidase (MAO) inhibitor, which was administered to 25 patients who had been refractory to other migraine chemoprophylaxis. In 20 of these patients there was a significant therapeutic response. It is worth noting that MAO inhibitors seldom have been used in the

last few years because of their potentially serious side effects and the extremely variable response to them.

In patients with migraine who are also subject to depression, the antidepressants are more effective than the anxiety-reducing drugs. Among the most effective are the dibenzazepine derivatives, imipramine hydrochloride (Tofranil®) and amitriptyline hydrochloride (Elavil®).

Other agents such as the barbiturates, phenothiazine derivatives, and minor tranquilizers may be beneficial in migraine for short-term prophylaxis by reducing anxiety and for the moment improving the patient's ability to handle stress.[27]

A beta-adrenergic blocker, propranolol hydrochloride (Inderal®), has been tested in patients with migraine and angina as well as in migraine patients without angina. In some selected cases, this medication has been reported to be effective as a prophylactic treatment. We have used this drug in a few cases and were not overly impressed by our results.

Diuretics have not proven successful in the treatment of migraine although the patient with edema (especially before the menses) feels more comfortable following fluid loss. There is no evidence of a close correlation between retention of water and migraine attack.

The management of psychological problems is one of the most important aspects of therapy since migraine attacks are usually precipitated by emotional factors. Psychotherapy may be employed, varying from supportive to long-term treatment according to the situation. It must be structured to meet the needs of the individual patient, and its success will depend upon the patient's insight, his personality, and his resistance to or acceptance of help.

Supportive therapy includes the removal or reduction of precipitating or provoking factors such as overloading environmental demands, fatigue, exposure to glare or flickering lights, alcohol, foods containing tyramine, offending allergens, and the like. Psychological conditioning regarding certain foods may precipitate a migraine attack. It is sensible for the patient to avoid any food so identified.

Surgery

In general, the surgical therapy of migraine is not effective and should be discouraged.

It should be apparent that patients with migraine cannot be treated in any stereotyped pattern.

Muscle-contraction Headache

The management of muscle-contraction or tension headache must address itself to the relationship that exists between this type of headache and anxiety-producing situations. In practice it is desirable to distinguish between psychogenic and muscle-contraction headaches when considering them as abstract entities. The pain may be a neurotic symptom in the former and represent a symbolic attempt to resolve a mental conflict. On the other hand, muscle-contraction or tension headache results from a peripheral end organ discharge that is triggered by an emotionally induced physiological dysfunction.

It is not easy to distinguish between these two types of headache in actual practice, since components of both types may be present. Since the purely psychogenic headache is rarely encountered, major attention can be directed to the management of the muscle-contraction or tension headache.

For symptomatic treatment of muscle-contraction headache, non-narcotic analgesics should be combined with sedatives or tranquilizers having muscle-relaxant properties. This combination raises the pain threshold and also affects the patient's perception of pain. The dosage of these drugs is highly individualized, and the patient must be carefully followed.

Drugs cannot replace insight in the prophylaxis of muscle-contraction headache but they do have value in reducing anxiety until the patient learns how to handle his problems more effectively. Muscle-relaxants with tranquilizing action are the medical treatment of choice for the prevention of muscle-contraction headache. Again, the dosage is highly individualized. The use of antidepressant agents is beneficial in patients who are depressed.

A useful though limited role can be assigned to physical medicine in the treatment of muscle-contraction headache. The patient with this type of headache may benefit from correction of faulty posture, hot packs, and gentle massage to the involved area, and infiltration of local areas of tenderness. However, over-treatment may create anxiety and thus increase the chronicity of the problem.

It must be emphasized that the most effective prescription in treating chronic muscle-contraction headache is dynamic psychotherapy, which tries to find the source of conflicts within the personality of the patient.

There is a group of patients with muscle-contraction headache in whom an underlying structural difficulty in the muscles, joints, or fibrous tissues seems to be the primary cause of headache. Obviously, specific treatment is indicated and may result in considerable or lasting improvement. Since this group of patients seldom appears without some anxiety and tension factors in their lives, treatment must also be directed toward resolution of these.

Conclusion

Increasing knowledge of the influences operating at the chemical, neurophysiological, and psychological levels are bound to contribute to better understanding of the pathogenesis of headache and further advances in its treatment.

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Combination Techniques for Preservation and Shipping of Human Cadaveric Kidneys

H M Kauffman, MD et al, Milwaukee County General Hospital, Milwaukee, Wis: *Transplantation* 12:389–391 (Nov) 1971

Cadaveric kidney preservation has been accomplished by surface cooling, flushing the kidney with a cooled extracellular fluid, and continuous extracorporeal pulsatile perfusion.

Combination techniques, in which the kidney is initially preserved by continuous pulsatile perfusion and then flushed and stored in extracellular fluid for shipping, have a great clinical appeal, particularly when a given kidney cannot be utilized by the harvesting team. However, canine data demonstrated an unacceptably high percentage of inadequate function of kidneys that were initially subjected to continuous pulsatile perfusion and then stored in a slush solution.

Four consecutive human cadaver kidneys were preserved on the Belzer Perfusion Apparatus from 8½ to 16½ hours, flushed with extracellular fluid and shipped to three separate transplant centers. Transportation times ranged from 3½ to 8½ hours with total ischemia times of 15 to 22 hours.

All four kidneys produced urine in the immediate postoperative period and each resulted in a satisfactorily functioning graft.

One recipient required two hemodialyses in the post-transplant period while the other three required none.

Differences between the present human data, which indicate that combination techniques of preservation result in satisfactory kidney function, and the canine data are attributable either to inherent differences of human and canine kidneys or to minor, but important, differences in the combination preservation techniques.

Since some investigators are unwilling to ship, or receive, human cadaveric kidneys that have been initially preserved by continuous pulsatile perfusion, a careful reevaluation should be made of the canine data in order to prevent needless discarding of functionally acceptable human cadaveric kidneys. □

DRUG RESEARCH: Azothioprine

Azothioprine in combination with prednisone provided greater relief from systemic lupus erythematosus—an inflammatory disease of the connective tissue—than did prednisone alone in a study conducted by Dr. M. Sztejnbok and associates of Brooklyn, N.Y.—AMERICAN DRUGGIST, Jan. 24, 1972 □

DRUG RESEARCH: Phosphamide

Phosphamide provided improvement in 11 of 20 patients with rheumatoid arthritis, according to a team of Zurich, Switzerland researchers headed by Dr. W. Kunz. The dose was 200 mg to 400 mg phosphamide daily.—AMERICAN DRUGGIST, Nov. 15, 1971 □

Comments on Treatment

Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Lithium Carbonate in Manic-Depressive Illness

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THE ELEMENT LITHIUM was first discovered in Europe in 1817. In the past 155 years, lithium in the form of inorganic compounds has been used for various purposes in industry, agriculture, and medicine.

The name lithium is derived from the Greek word "lithos" meaning stone. It is one of the alkali metals like sodium and potassium. Because of its long half-life, it is generally unsuitable for radioisotope tagging to determine its site of action in humans.

As early as the second half of the nineteenth century, lithium-containing compounds were employed in the treatment of gout. However, subsequent experience with lithium demonstrated that it had little therapeutic effect in the treatment of gouty arthritis.

In 1913, Cleveland[1] described the symptoms of toxicity from lithium chloride after he had himself ingested 8 gm per day of lithium chloride for three days. Very little, if any, significance was found in the literature concerning lithium until 1949 when Corcoran *et al*[2] described lithium intoxication in cardiac patients who had used lithium chloride as a salt substitute. Peters,[3] in this JOURNAL, described choreo-athetosis and other symptoms of lithium intoxication secondary to the ingestion of lithium chloride. A few deaths were attributed to lithium chloride, and its use as a salt substitute was discontinued.

In 1949, Cade[4] first reported the use of lithium carbonate in the treatment of the manic type of

From the Clinical Pharmacology Service, Wood Veterans Administration Center, and The Medical College of Wisconsin, Milwaukee, WI 53193.
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manic-depressive illness. Schou[5] in 1956 described improvement on lithium carbonate with manic-depressive patients of the manic type. In 1960, Gershon and Yuwiler[6] deplored the neglect of lithium as a promising therapeutic agent in the treatment of mania. This neglect was obviously based on the unfortunate consequences of the rather indiscriminate use of lithium chloride as a salt substitute in cardiac patients. In the last ten years since Gershon's article, interest in lithium carbonate has greatly increased.

From the data of medical reports published by various investigators, lithium carbonate was found to be highly effective in the treatment of the manic type of manic-depressive illness.[7-11] Recently there have been some studies, though inconclusive, indicating the effectiveness of lithium carbonate in the treatment of acute depressed phase of manic-depressive illness.[11-13] Substantial evidence also points to the prophylactic value of lithium carbonate in reducing the incidence of relapses in manic-depressive illness.[14-17]

In 1970, lithium carbonate was manufactured by three pharmaceutical manufacturers, (Eskalith® by Smith, Kline & French; Lithonate® by Rowell, and Lithane® by Roerig), for the treatment of manic-depressive illness. It would appear at the present time that lithium carbonate represents the specific drug in the treatment of manic-depressive illness.

Pharmacology

Lithium carbonate is completely absorbed in the gastrointestinal tract. It is excreted almost entirely in the urine with an insignificant amount being found in the feces. After the ingestion of lithium carbonate, it is detected in the urine within 15 to 30 minutes. More than 50% is excreted over the next 4 to 8 hours. This explains why it is most effective when given in divided daily doses. The renal tubules are the sites of reabsorption. The remainder is excreted rather slowly and is still detectable in the urine several days after ingestion of a single dose of lithium carbonate. Lithium passes through the blood brain barrier rather slowly. It passes through the placenta and is also found in the milk of lactating mothers.

Lithium is intimately related to sodium and potassium metabolism. Following the ingestion of lithium carbonate and at approximately the peak of plasma lithium level, there are slight decreases in plasma sodium and slight increases in plasma potassium levels. Cade[18] reported in manic patients diminished potassium levels which returned to more normal levels after treatment with lithium carbonate. Nielsen[19] reported higher serum magnesium levels in manic patients, and these levels were lowered after treatment with lithium carbonate. These and other studies would certainly suggest that lithium is capable of replacing and interchanging with other cation electrolytes within the body. A slight neutrophilia and a minor elevation of blood sugar in patients on lithium carbonate have been reported.

Lithium has been shown to cause flat and inverted T waves on the electrocardiogram in some patients.[7] The presence of U waves after treatment with lithium carbonate was recently noted.[20] These U waves disappeared after the lithium carbonate was discontinued. The clinical significance of these electrocardiographic changes is not known. A variety of electroencephalographic changes of probably negligible significance are observed in some patients receiving therapeutic doses of lithium carbonate. These changes were primarily in relation to voltage and frequency.

The mechanism of action of lithium ions is not known, although it may be related to catecholamine metabolism or electrolyte metabolism. It was found that norepinephrine and other central catecholamines were elevated in mania, while therapy with lithium carbonate led to reduction of norepinephrine levels. This would explain the efficacy of lithium carbonate in mania but not in the manic-depressive illness of the depressed type, where the norepinephrine level is reduced. Because of the similarity between lithium and sodium as alkali metals, there is possibly partial disruption of nerve conduction. Other electrolytes including potassium, magnesium, and calcium also may play a role in the mechanism of action of lithium ion in manic-depressive illness.

Dosage, Blood Levels of Lithium and Concomitant Therapy

On the basis of our experience and many other studies, guidelines for the use of lithium carbonate in the treatment of manic-depressive illness can be readily followed.

The patient's status should be determined by a thorough physical examination. Complete blood count, urinalysis, serum electrolytes, liver profile, and kidney function also should be obtained and evaluated. A baseline electrocardiogram should be obtained. Following this assessment, lithium carbonate can be administered in doses of 300 mg, three or four times daily for the first week. Beginning the second week, the total daily dose is increased by 300 mg if the serum lithium level is not in the therapeutic range. Thereafter, dose adjustments are made according to serum lithium level rather than to any clinical response or lack of response. Patients with manic-depressive illness of the manic type may respond rather dramatically in 48 to 72 hours and usually improve in 7 to 14 days. Manic-depressive patients of the depressed type improve slower but usually within 10 to 28 days. If no improvement occurs in either the acute manic

or acute depressed phase, lithium carbonate is generally discontinued after approximately one month of therapeutic trial. If the patients are continued on a maintenance dose of lithium carbonate, 900 to 1200 mg per day in divided doses generally maintains an adequate serum lithium level. Present evidence indicates maintenance dosage can and should be continued indefinitely if no serious side effects develop. Many patients continue on maintenance dosage of lithium carbonate after over five years of treatment without any adverse effect.

When lithium carbonate treatment is initiated during the acute manic or acute depressed phase of manic-depressive illness, serum lithium levels should be done at least once weekly during the first month. The therapeutic level is in range of 1.0 to 1.5 mEq/L. The dose adjustment should be made in order to attain this level. Toxic manifestations usually do not occur when the serum lithium level is below 2.0 or 2.2 mEq/L.

After the therapeutic level of lithium is attained and a favorable clinical response has occurred, the dose of lithium carbonate can then be gradually reduced so that a serum lithium level of 0.7 to 1.1 mEq/L is maintained. During the second month of treatment, serum lithium levels should be obtained every other week; and thereafter monthly serum lithium levels are usually adequate so that the proper maintenance dosage of lithium carbonate can be prescribed.

Currently there is no evidence which would contraindicate the concurrent use of lithium carbonate with other psychotropic drugs. There is, in fact, some evidence to suggest that concomitant use of lithium carbonate with antidepressants of the tricyclic type may enhance a remission in a depressed phase of manic-depressive illness. Chlorpromazine or other antipsychotic drugs can be indicated for an acutely manic patient. It can be given concurrently when the lithium carbonate is begun and can be generally discontinued or at least reduced within a few days. Sletten *et al*[21] reported that lithium retention and toxicity are not more likely to occur with concurrent lithium and chlorpromazine therapy. Their study, in fact, suggested that chlorpromazine might reduce the capacity of manic patients to retain lithium. On that basis, it may be necessary to consider higher doses of lithium carbonate to attain and maintain a therapeutic level if chlorpromazine is used with lithium carbonate.

Toxicity and Side Effects

The toxicity of lithium has been known since early in the twentieth century and reaffirmed in the late 1940s when lithium chloride was used popularly as a salt substitute. Lithium salt is not necessarily more toxic than other widely used drugs such as digitalis, insulin, phenothiazines, steroids, and so forth. The case reports of lithium toxicity in the literature appeared more due to the lack of understanding of this compound and the injudicious use of it. Familiarity with drug, its use, and the effective management and observation of the patient taking the drug are more than adequate means of avoiding toxicity. The benefits to be derived from lithium carbonate far outweigh its potential toxicity when usual observation and control are exercised.

Side effects are generally minor at usual doses with therapeutic serum lithium levels. Transient nasal stuffiness, polyuria, episodic diarrhea, mild anorexia, and pyrosis usually require no change in the treatment regimen. They can be treated symptomatically or not at all. Nausea, vomiting, and persistent diarrhea may or may not require modification of the treatment regimen. Tremor and pruritus have been observed in other studies as well as ours, and the means in which they are treated vary with the severity of the symptoms. They may be of such a degree as to necessitate reduction or discontinuation of lithium carbonate.

When side effects of lethargy or fatigue are noted, reduction of the dosage of lithium carbonate is indicated. The general side effects of lithium carbonate are summarized in Table 1. These are divided on the basis of the organ systems and are essentially similar to those presented by Gershon and Yuwiler.[6]

TABLE 1—*General Side Effects and Toxicity of Lithium Carbonate*

Gastrointestinal
1. Anorexia
2. Nausea and vomiting
3. Thirst and dryness of the mouth
4. Diarrhea
5. Weight loss

Neuromuscular
1. General muscle weakness
2. Ataxia
3. Tremor
4. Muscle hyperirritability (fasciculation, twitching, and clonic movements)
5. Choreo-athetotic movements
6. Hyperactive deep tendon reflexes

Central Nervous System
1. Retarded mentation
2. Somnolence
3. Confusion, disturbed behavior, or restlessness
4. Dysarthria or slurred speech
5. Blurring of vision
6. Dizziness or vertigo
7. Epileptiform seizures

Cardiovascular
1. Pulse irregularities
2. Fall in blood pressure
3. ECG changes
4. Peripheral circulatory failure
5. Circulatory collapse

Miscellaneous
1. Polyuria
2. Glycosuria
3. General fatigue
4. Lethargy and tendency to sleep
5. Dehydration
6. Nontoxic goiter
7. Micrographia

Precaution

Patients with mild cardiac, renal, or liver disease need not be entirely excluded from using lithium carbonate. Its potential risk in such patients must be carefully weighed against those of using chlorpromazine, haloperidol, or other antipsychotic drugs for treating the manic-depressive illness.

The use of lithium carbonate in children, pregnant women, and elderly patients is still under considerable scrutiny and further caution should be exercised in this situation. Goldfield and Weinstein[22] advised caution even though only 2 of their 45 pregnant patients (5%) taking lithium carbonate delivered fetuses with congenital abnormalities. Van Der Velde[23] reported three cases of acute toxic reaction in elderly patients receiving lithium carbonate and suggested that extreme sensitivity to lithium exists with some elderly patients.

Conclusion

Lithium carbonate represents one of the promising weapons in our psychotherapeutic arsenal. It appears at this time that lithium carbonate is a drug which is specific for a single disease entity, manic-depressive illness. Evidence continues to weigh overwhelmingly in favor of lithium carbonate in the treatment of the manic phase of manic-depressive illness and the prevention of recurrent episodes of manic-depressive illness, either the manic or the depressed phase. Evidence also suggests that lithium carbonate may be effective in the treatment of the depressed phase of manic-depressive illness. More remains to be studied relative to the nature and site of action of lithium in manic-depressive illness and its application in other psychiatric disorders.

Clinically, lithium carbonate can be given in effective doses with an adequate margin of safety. But knowledge of its side effects, toxicity, and precautions are necessary preceding the use of lithium carbonate. Frequent serum lithium levels provide the physician not only with information about the lithium level but also information as to whether the patient is in fact taking his medication. Finally, lithium carbonate can be safely continued indefinitely in the prevention of recurrent episodes of manic-depressive illness.

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DRUG RESEARCH: Imipramine

Because of imipramine HCl, 35 non-psychotic school-phobic children have returned to classes. The drug was administered in doses of 100 mg to 200 mg daily as part of a multidiscipline treatment program. Imipramine was found superior to placebo in inducing school return and in global therapeutic efficacy, according to the researchers, Drs. R. Gittelman–Klein and D. F. Klein of Hillside Hospital, Glen Oaks, N. Y.—AMERICAN DRUGGIST, Nov. 15, 1971 □

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A PHYSICIAN'S VIEW

Now Is the Time to Begin: A Concept for Maternity and Infant Care in the Future

THOMAS A. LEONARD, MD
Madison, Wisconsin

A REVIEW OF ALL MATERNAL DEATHS in the State of Wisconsin by the Wisconsin Maternal Mortality Study Committee over the past 18 years has produced adequate data for a comprehensive knowledge concerned with these deaths. The materials obtained through these studies have been utilized in every conceivable manner in order to bring this information directly to those involved with the delivery of perinatal care. Seminars, institutes, postgraduate nursing courses, tape recordings, and publications have all played a part in the accomplishment of continued education.

Where necessary, facilities and equipment in obstetrical departments have been updated. Blood, fibrinogen, rubella vaccine, and Rh_0 (D) immune globulin (human) [RhoGAM®] have been made readily available. Where elements of possible preventability have existed, alternate managements have been suggested for future utilization in similar circumstances.

Reprint requests to: Thomas A. Leonard, MD, 5717 Century Avenue, Middleton, WI 53562.
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Through a tremendous cooperative effort on the part of the physicians of Wisconsin, obstetrical nurses, hospitals, the Wisconsin Division of Health, the State Medical Society of Wisconsin, and the dedicated members of the Study Committee, there has been a gratifying and significant decline in maternal deaths, especially in the major categories of hemorrhage, infection, and toxemias (Table 1).[1]

And still, deaths do occur which possibly could have been prevented, provided that full applicability of the more recently evolved contributions concerning the safety of child-bearing had been made. Maternal mortality study committees must involve themselves with morbidity as well as with mortality and with the interrelationship between safety for the offspring and circumstances which endanger the mother. They also must consider the employment of all of the principles of preventive medicine toward the vital process of procreation of our kind. They must expend all efforts toward bringing into focus some of the means by which further improvement can be attained.

The Role of Perinatal Associations

The Wisconsin Perinatal Association came into being in November 1970 and in March 1971 joined with Minnesota, Iowa, Nebraska, North Dakota, and South Dakota to form the Great Plains Association for Perinatal Care. Both of these

[1]TABLE 1—*Comparison of 15-year experience of maternal deaths in Wisconsin: 1953–1967*

	1953		1954		1955		1956		1957		1958		1959		1960	
Live birth	88,408		91,570		92,333		93,496		96,398		95,950		98,518		99,493	
Fetal death	1,251		1,216		1,233		1,235		1,278		1,246		1,222		1,341	
Neonatal death	1,508		1,482		1,670		1,605		1,601		1,676		1,728		1,644	
Infant death	2,069		2,002		2,175		2,133		2,145		2,250		2,295		2,173	
	Number and Percent															
Vital Statistics, Div. of Health																
Maternal Deaths	38	100.0	34	100.0	22	100.0	20	100.0	35	100.0	29	100.0	34	100.0	27	100.0
Hemorrhage	8	21.1	8	23.5	6	27.3	8	40.0	7	20.0	3	10.4	8	23.5	5	18.5
Sepsis	3	7.9	8	23.5	4	18.2	1	5.0	2	5.7	4	13.8	12	35.3	11	40.7
Toxemia	13	34.2	4	11.8	6	27.3	6	30.0	9	25.7	7	24.1	4	11.8	4	14.8
Other	14	36.8	14	41.2	6	27.3	5	25.0	17	48.6	15	51.7	10	29.4	7	25.9
	Number and Percent															
Maternal Death Study of State Medical Society																
Maternal Deaths																
Direct	39	100.0	34	100.0	24	100.0	22	100.0	35	100.0	31	100.0	34	100.0	28	100.0
Hemorrhage	22	56.4	17	50.0	9	37.5	12	54.5	12	34.3	12	38.7	14	41.2	6	21.4
Sepsis	2	5.1	4	11.8					1	2.9	8	25.8	9	26.5	11	39.3
Toxemia	8	20.5	2	5.9	3	12.5	4	18.2	5	14.3	4	12.9	3	8.8	2	7.1
Other	7	18.0	11	32.3	12	50.0	6	27.3	17	48.6	7	22.6	8	23.5	9	32.2
Indirect	14		18		8		3		11		9		4		8	
Not Related	11		8		8		7		9		1		6		8	
Not Stated	2															
Total	66		60		40		32		55		41		44		44	

	1961		1962		1963		1964		1965		1966		1967		Total	
Live birth	98,435		94,497		91,605		88,910		82,919		80,412		75,797		1,368,741	
Fetal death	1,243		1,114		1,184		1,112		1,042		958		867		17,542	
Neonatal death	1,693		1,473		1,563		1,399		1,375		1,289		1,149		22,855	
Infant death	2,235		1,929		2,060		1,848		1,829		1,640		1,484		30,267	
	Number and Percent															
Vital Statistics, Div. of Health																
Maternal Deaths	28	100.0	26	100.0	20	100.0	16	100.0	13	100.0	21	100.0	9	100.0	372	100.0
Hemorrhage	9	32.1	2	7.7	8	40.0	2	12.5	3	23.1	4	19.0	1	11.1	82	22.0
Sepsis	5	17.9	6	23.1	3	15.0	2	12.5	5	38.5	9	42.9	2	22.2	77	20.7
Toxemia	2	7.1	3	11.5	5	25.0	1	6.3	3	23.1	2	9.5	1	11.1	70	18.8
Other	12	42.9	15	57.7	4	20.0	11	68.7	2	15.4	6	28.6	5	55.5	143	38.4
	Number and Percent															
Maternal Death Study of State Medical Society																
Maternal Deaths																
Direct	28	100.0	21	100.0	16	100.0	12	100.0	10	100.0	15	100.0	(figures incomplete)		(figures incomplete)	
Hemorrhage	15	53.6	8	38.1	7	43.7	7	58.3	2	20.0	4	26.7				
Sepsis	3	10.7	3	14.3	5	31.3	2	16.7	3	30.0	7	46.7				
Toxemia	2	7.1	2	9.5	2	12.5	1	8.3	1	10.0	0					
Other	8	28.6	8	38.1	2	12.5	2	16.7	4	40.0	4	26.7				
Indirect	4		12		9		6		10		10					
Not Related	3				5		2		4		3					
Not Stated																
Total	35		33		30		20		24		28					

organizations have accepted the term "perinatal" as not only concerned with the factors immediately surrounding the birth process, but also have had the intent to define perinatal in a much broader scope. This goes beyond conception, pregnancy, delivery, and infant care to many factors that might seem quite remote but yet are related.

An important step forward is the establishment by the Wisconsin Perinatal Association of the High Risk Centers. These are for the care of the pregnant woman who is compromised by endangering complications and for the newborn infant who is in need of specialized facilities and care in order to survive. Such centers have been established on a regional basis throughout the state of Wisconsin. There are problems peculiar to regions such as distances between hospitals, transportation, and other matters which must be dealt with on a regional basis.

There is a great need for the efforts of perinatal associations to deal with the complications associated with pregnancy which endanger both mother and infant. These efforts should be supported and encouraged in every possible way. We must begin to think not only of dealing with these serious complications which interfere with safety of mother and infant after they have happened but, in addition, to giving specialized care after the fact, to look toward means of preventing them from occurring in the future. Not all of the tragic consequences can be so easily dismissed, but many of them can. We must fully apply present as well as new knowledge as it evolves, if we are to approach the visionary goal of ultimate safety for the childbearing woman and of the assurance of producing quality offspring capable of surviving.

Factors Involved in Preventability

Factors involved in preventability include: (1) Education, (2) family planning, (3) regional approach to record data collection system with retrievability, (4) full utilization of the latest genetic knowledge, (5) avoidance of drugs and known toxic substances that might have teratogenetic effects, (6) properly timed immunization of certain viral diseases such as rubella, (7) adequate use of RhoGAM® to reduce and abolish the maternal and infant pathologies that are associated with Rh isoimmunization of the mother, and finally (8) an attempt to prevent in some manner the "unwanted pregnancy."

Pregnancies which are undesirable because of the existence of serious medical or surgical complications and which are most certain to be incompatible with pregnancy, should receive special emphasis with regard to prevention.

Education

Ignorance and its counterparts of fear and superstition are the great deterrents to progress. This precept holds true in perinatology as in other fields of endeavor. Continued education directed toward those professionals who are responsible for maternal and infant care has been instrumental in keeping such care on a high level. Such future educational endeavors should be directed toward the team approach and should not only involve the physicians and obstetrical nurses but also the licensed practical nurse, the attendants, social workers, as well as the much involved and concerned patient.

The first education about reproduction that usually comes to the patient is after she has conceived and makes her first visit to her physician. This factor constitutes a gross defect in preventive care. Each newborn female child is a potential mother and each male child a potential father. They should be adequately prepared to assume their roles in human reproduction. Such preparation should have its beginning at the earliest period of life when receptivity is possible, and it should be continued until such time in life when its fullest impact has been achieved.

Such educational efforts should be concerned with sexuality, its purposes and its problems, family and community life, population concerns of the nation and the world. These efforts also must consider the safety and dangers of childbearing, how to achieve one and avoid the other, and how to insure quality offspring. Those who assume responsibility for imparting such knowledge, especially to the immature, must be well qualified to do so. And all of those who charge themselves with providing care must impart to the patient, or better still, to the prospective patients, such knowledge as is deemed necessary to lessen the gap between those who provide the care and those who receive it.

Knowledge on the part of the individuals intending reproduction can bring them into the fold of the team concept of care. They then can have a sense of security because they know that those who are providing them care are sharing with them the very best of their knowledge, and sharing with them the responsibilities for their safety. Currently the early adolescent, the newly married, and even those who have borne children know little of the important concerns regarding reproduction. Developing education along the lines discussed above can be a large factor in preventive medicine as applied to maternity and child care.

Family Planning

There are many major concerns for the advisability of pregnancy, for its avoidance, or in certain circumstances for its termination. Pregnancy is advisable when it is desired and when it fits in with the social and economic aspects of the family and of the community. Family planning should be available to those who desire some control in the spacing of children as well as to the ultimate size of the family. There are certain circumstances, complicated by serious medical or surgical conditions, when pregnancy should be avoided. These could be incompatible with pregnancy and the ultimate outcome might be disastrous. Where there are genetic factors which would, most certainly, be responsible for an offspring that would be seriously handicapped, contraceptive methods that are 100% certain—including sterilization if necessary—should be employed. The unwanted pregnancy, and there are many of these, should be avoided by adequate contraceptive means. Family planning advice, assistance, and means should be readily available through proper channels for all of those who find themselves with the problems listed above.

The teenage pregnancy constitutes problems of special import. In 1967 there were 197,000 school-age children under 18 years of age in the U.S. who gave birth, and this rate has been increasing at about 4,000 per year. At the time of delivery 78,000 of these were unmarried. One half of teenage marriages complicated by pregnancy ended in divorce in the first four years.[2] In the State of Wisconsin 6,795 of 75,000 live births were to unmarried mothers; 45% of these were to girls under 20 years of age; 20% had had previous children out of wedlock (reported in 1970).[3]

The American College of Obstetricians and Gynecologists, being aware of the tremendous adverse impact such pregnancies have upon the lives of those involved, including the unwanted child, has advocated an increased educational effort. When the patterns of sexual behavior repeatedly expose such teenagers to pregnancies, the College advocates that preventive means should be offered and made available to them, with or without parental consent. In the latter case the minors must sign consent forms.[4] Such recommendations are purely preventive. There still remain the problems of prenatal care, the managements of the numerous complications that are attendant upon such early-age pregnancies, and the many social and economic problems that are associated with the recently delivered and bewildered teenager and her unwanted child. Perhaps some inroad can be made upon this aspect of perinatology by intensifying the educational efforts directed toward the pre-adolescent as well as to the adolescent, and where necessary, the judicious application of preventive contraceptive means.

The termination of pregnancy can be a means whereby preventive medicine can be applied to perinatology. Pregnancies which would endanger the life of the mother or which would most certainly produce seriously handicapped offspring should be terminated. The advisability of terminating all unwanted pregnancies has some merit, but this issue is very controversial and has numerous facets which need further exploration. The development, as well as the acceptance, of the ideal contraceptive would solve much of this problem. It is not the intent of this report to discuss the moral issues of the patient-physician decision-making aspect of abortion.

The Rh Factor—Its Consequences and Management

About 15% of the Caucasian race are Rh negative. When erythroblastosis occurs, all of the mothers are Rh negative and do not have the antigen which all of the fathers of erythroblastotic infants have. Such fathers who do have this antigen are designated Rh positive. Because of the escape of fetal red blood cells into the maternal circulation through the fetal-maternal circulation, isoimmunization occurs through a simple antigen-antibody relationship. Once the mother is sensitized all Rh positive infants in future pregnancies will be affected. Each succeeding pregnancy as a rule produces more severely affected infants.[5] However, by amniocentesis and the determination of the quantity of bilirubinoids the degree of the effect can be determined. By means of intra-uterine transfusion of the infant some of the red blood cell destruction can be compensated. By means of one or more such transfusions many of these infants can be safely delivered after viability has been reached, and can survive. The infant who has been delivered with severe red blood cell destruction should have an exchange transfusion. The consequences for the mother who is severely sensitized and who is not properly cared for during a pregnancy has the likelihood that she will suffer intra-uterine demise of the fetus. In such cases there develops intravascular clotting of the maternal

blood with the resultant defibrinogenization. At the time of delivery there is a possibility of uncontrollable hemorrhage unless there is replacement of the fibrinogen or prevention of the intravascular clotting by administration of heparin.

Much rarer is the hemolytic disease of the newborn due to AB-O incompatibility. The principles involved in the management are the same as for the Rh effects in mother and fetus.

We now have the means of preventing all of the above pathological consequences in both mother and infant. There has been developed an anti-$Rh_0(D)$ globulin (RhoGAM®) which, if administered intramuscularly in the recommended dosage within 72 hours after delivery, can prevent the isoimmunization. Occasionally more than the usual recommended dosage of RhoGAM® will be needed to prevent isoimmunization of the mother. This can be determined by a special technique of counting the fetal red cells in the maternal circulation. RhoGAM® will not overcome isoimmunization which already exists. The final eradication of hemolytic disease of the newborn due to Rh factor and to the AB-O incompatibilities and the complications which affect the mothers of such infants can be accomplished by the diligent application of this immunological principle. It is recommended that the anti-$Rh_0(D)$ globulin be given not only to those Rh negative women who have Rh positive husbands and who achieve term or near-term deliveries but also to those who are not already sensitized. Also it should be given to all such women who are pregnant and undergo spontaneous or surgical terminations of pregnancy, who threaten to abort, who have bleeding episodes during pregnancy, who have amniocenteses performed, or who have manipulative procedures such as external version or examination under anesthesia. The Rh and AB-O effects are just as preventable as several other well known diseases for which we have immunological substances.

Rubella

When the mother has been infected with rubella during the first three months of gestation, there is a high probability that the infant will be born with serious gross development defects. We now have the means to totally eliminate this disease by the proper utilization of the specific vaccine. However, certain precautions should be taken. The prospective mother should not be vaccinated during pregnancy nor within three months before she expects to conceive to avoid the teratogenetic effects of the vaccine. The administration of rubella vaccine immediately postpartum also must be subjected to contraceptive control. Of 53,000 women so vaccinated, 5.6% became pregnant within two months following delivery.[6] The State of Wisconsin has available testing for rubella hemagglutinins in 28 private laboratories in the state and at the State Laboratory of Hygiene in Madison. Prenatal examinations should include this test where there has been a known exposure to rubella and where the patient does not know her history regarding this disease. When positive disease develops, the patient should be informed of the possible consequences for the fetus and definitive procedures advised. It is recommended that all women of childbearing age be vaccinated against rubella, that this be done during the nonpregnant state, and that positive means of contraception be utilized for three months following such vaccination. The duration of immunity following vaccination is thought to be seven to ten years. Therefore retesting and revaccination must be considered. All children should be so immunized.

Genetics

X chromosome abnormalities occur in approximately one in every 800 females and one in every 700 males. The disabilities are both medical and

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psycho-social. Some may be apparent at birth while others may be latent and become manifest later in life. However, the chromosome abnormality is present at birth and available for discovery. There are interrelated conditions such as Turner's syndrome and its variants, Klinefelter's syndrome and variants, true hermaphroditism, and other nonspecific disabilities including alteration in stature, abnormal function in sex organs, somatic anomalies, mental retardation and its social maladjustment, and related psychiatric problems.[7]

Simple Mendelian inheritance can play an important part in the practice of both obstetrics and gynecology. The gene has an allele which occupies a specific locus on a homologous chromosome.[8]

Tay-Sachs disease has come into prominence recently as an inheritable disorder in about one in every 300 births in the Jewish race of Eastern European origin.

On an analysis of 16,931 infants, trisomy 21 was found in one out of every 700. Viral infections at or shortly following the time of conception were thought to be the etiologic factor.[9]

Somewhat controversial as teratogenetic agents are the mind-altering drugs such as lysergide (LSD). Seven infants with major congenital malformations were delivered from 62 female users of this drug.[10] Many studies indicate that there is not yet adequate evidence to positively incriminate LSD as a mutagenic substance.

Among the inborn errors of metabolism, 18 familial metabolic disorders can be detected in tissue culture from amniotic membrane, and nine of these can be demonstrated in amniotic fluid cell cultures and by biochemical and enzyme studies of the fluid. Of 400 such amniocentesis procedures only one patient aborted. Some of the conditions that are amenable to determination by chromosome analyses and prenatal biochemical and enzyme studies have the possibility of preventive intra-uterine treatment in the future.[11]

In 4,500 babies of mothers over 34 years of age, the defect rate in the offspring was 1% compared to the average of 0.5% for all newborns.[12]

Prenatal diagnosis from the amniotic fluid, which is obtained by amniocentesis after 13 weeks gestation, when successful, allows a positive determination as to whether an infant is affected by genetic disorders. Abortion can be sought if the infant is known to be affected, and the risk of aborting an unaffected infant is reduced to zero when the technique of amniocentesis is used.[13]

About 5% of all children have congenital defect; 20% of these are due to inheritance; another 20% are caused by environmental factors; and the remaining 60% are due to combinations of inheritance and environment.[14]

The science of genetics has received tremendous impetus during the last decade and should assume its proper place in the preventive aspect of maternal and infant care. As the chromosome analysis becomes more readily available, it seems that the application of this knowledge should be applied premaritally, or at least preconceptually, to both male and female prospective parents. With proper counseling many of those infants now doomed to be born with all the handicaps of inheritable defects will never be conceived. And in those cases where conception has already occurred, the properly timed amniotic fluid cell study can indicate those infants with gross defects so that advice as to the termination of such pregnancies may be given. Where conceptions have been subjected to hazard by environmental factors such as viral infections, toxic substances and drugs, irradiation, or any other teratogenetic possibility, amniocentesis and fluid cell studies should again govern which pregnancies should continue and which should be terminated. We should have as our goal the maximal utilization of chromosomal studies toward eradicating the unhappiness which comes to parents of such handicapped children, the tremendous problems which come to the handicapped themselves, and the social and economic factors involved in their care. Further exploration should be done in the diagnosis of metabolic disorders by studies of amniotic fluid and of the possibilities of intra-uterine prenatal treatment of infants so affected.

The Computer—A Solution

In order to bring about an effectual application of preventive medicine in perinatology, it will be necessary to have available data on each potential mother and father. Such information should include genetic profiles on both potential parents. On the potential mother there should be a record of any physical or medical conditions including all of the metabolic diseases, vaccinations against teratogenic viruses, and familial history of hereditary disease. In the case of the mother who has already borne children, there should be information concerning

past pregnancies. As the practicality of chromosomal analyses increases, such computerized information should include a genetic profile on both prospective parents. All such information should be stored and should be retrievable for utilization in preconceptual counseling. Certainly such data should be valuable to those who administer care during the pregnancy and delivery as well as to the offspring. Perhaps the legal confidentiality of such information could be overcome by having the potential parent carry a coded card, and delivery of such a card to the physician would automatically nullify any legal redress. The physician could then retrieve the data for his utilization in care and counseling. Such a system is possible and seems pertinent. It should be developed on a regional basis such as that which is encompassed by the righ-risk centers. As the problems connected with such a system are solved, it could then be recommended for use in other areas.

Summary

This report has considered several aspects of maternal and infant care to which the principles of preventive medicine could and should be applied. These are the current problems for which we have the available knowledge to expect reasonable success. Some of these current difficulties are going to require more patience and perseverance than others for their eventual solution. The educational process by which the patient can become a part of the total team effort will not be a simple enterprise. The problems concerned with the teenage pregnancies most certainly will not be easily solved. Nevertheless, reason dictates that ways must be found.

In this report certain suggestions have been made which, at least, can constitute initial steps toward betterment in maternal and infant care by the diligent application of the principles of preventive medicine. The problems are not insurmountable. We have the means to resolve many of them. However, we must be visionary—we must be dedicated to a noble cause—and, we must be confident. Now is the time to begin!

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Immunofluorescent Studies in Patients with Farmer's Lung

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When lung sections from patients with farmer's lung were stained with fluorescein-labeled gamma globulins obtained from farmer's lung sera, the entire wall of the bronchioles stained brilliantly providing evidence that antigens *Micropolyspora faeni* are contained there in high concentration. This was seen in two patients with acute farmer's lung but not in two others with more chronic disease. Non-specific labeled anti-IgG produced no bronchiolar staining. Immunoglobulins IgG, IgA, and IgM were found in plasma cells and lymphocytes widely scattered throughout diseased lung. All farmer's lung patients showed great numbers of fluorescing histiocyte-like cells in sections stained with anti-C-3 complement. These findings suggest antigen-antibody complexes with fixed complement in the lungs of patients with farmer's lung, the first report of this phenomenon in such patients.

These findings suggest that at least part of the immune events in farmer's lung, involve the third component of complement. None of our lung biopsies have demonstrated necrotizing inflammatory lesions of the venules, nor have polymorphonuclear cells been found in the numbers seen in an Arthus reaction. A more plausible explanation appears to be a Type II or cytotoxic reaction, in which adsorption of an antigen or hapten (drug) renders the tissue cells temporarily susceptible to cytotoxic antibody and complement. Reaction of antibody with cell antigen complex may then bring on cellular destruction. The presence or absence of a delayed component in farmer's lung remains uncertain. □

Family Planning Comes of Age—?

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THERE EXISTS THE POSSIBILITY that reduction of maternal deaths can be accomplished through better use of family planning services. Currently we are witnessing widespread interest in the management of high-risk pregnancies, particularly in terms of fetal outcome. It is not the author's purpose to denigrate these efforts but one must at the same time examine other factors related to high-risk pregnancies. This report will focus on the inappropriateness of many of these high-risk pregnancies which all too often result in death of the mother, leaving behind several motherless children. Even those high-risk pregnancies not resulting in the tragedy of maternal deaths cause a shortening of life of the high-risk pregnant woman.

The Wisconsin Maternal Mortality Study Committee for years has carefully reviewed circumstances surrounding all maternal deaths. Information has been obtained from statistics of this Study Committee for use in presenting institutes and seminars to Wisconsin physicians. Dissemination of this information has undoubtedly been partly responsible for the reduction in maternal deaths occurring since the inception of the Study Committee.

Recently the author has been disturbed by the number of deaths occurring in women inappropriately pregnant. In fact, 32 of the last 48 consecutive deaths reviewed by the Study Committee occurred in women who had serious and important reasons for avoiding pregnancy. The reasons for avoiding pregnancy in these 32 cases were as follows:

1. **Medical complications contraindicating pregnancy—seven cases:**
   (a) Hypertension and previous cesarean section
   (b) Rupture of classical cesarean section scar at 22 weeks in previous pregnancy
   (c) Diabetes, chronic pyelonephritis, and previous cesarean section
   (d) Breast carcinoma treated 21 days before conception
   (e) Scleroderma
   (f) Obesity—259 lb—and previous cesarean section
   (g) Toxemia in two previous pregnancies and chronic hypertension.
2. **Medical complications as well as para 4 or higher—six cases:**
   (a) Para 5 and chronic hypertension—abortion requested by patient but denied by the hospital
   (b) Para 7 and chronic schizophrenia
   (c) Para 4 and Marfan's syndrome with coarctation of the aorta
   (d) Para 7 and chronic hypertension
   (e) Para 4 with four previous cesarean sections
   (f) Para 7 and five previous cesarean sections.
3. **Para 4 or higher prior to pregnancy resulting in death of the patient:**
   Twelve patients in this group left 70 motherless children.
4. **Unwanted pregnancies—seven cases:**
   In this group there were five deaths following illegal abortion and one following a cesarean section in an unmarried woman.
   Pulmonary embolism claimed the life of another unmarried woman.

Two points relative to high parity deserve emphasis: first, with increasing parity the risks of complications and death increase in a dramatic fashion, and secondly, the percentage of unplanned and unwanted pregnancies increases with increasing parity reaching an 80% undesired pregnancy rate in women who already have had four children. Thus, it can be estimated that 10 of the 12 pregnancies resulting in death of the women with four or more children were undesired pregnancies on the part of the patient.

The crux of the matter is what proportion of these pregnancies were desired? How many of the pregnant women made an informed choice to become pregnant in spite of their particular health problem or the fact that they already had 4 to 12 children? How many were given a complete appraisal of the risks of pregnancy? How many were advised of methods by which they might avoid inappropriate pregnancy? The answers to these questions are not known to the author but deserve very careful consideration by all physicians delivering health care to women, be they internists, family practitioners, general surgeons, or obstetricians and gynecologists.

Failure of, or failure to use, conventional contraceptive methods and techniques was responsible for some of the inappropriate conceptions. In those gravida with *serious* health problems therapeutic abortion must be made available to those women not wanting to assume the high risks of continuaton of the pregnancy. We physicians by tradition have been far too conservative in

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interpreting the legislative statutes relative to therapeutic abortion. Several of the 32 patients enumerated above had valid health problems, qualifying them for therapeutic abortions even within the framework of our present archiac Wisconsin statutes. Five of the 32 deaths occurred following illegal abortions performed by non-physicians. One death followed a cesarean section in an unmarried woman. In addition, the most tragic case was the gravida 7 para 5 woman with chronic hypertension of several years duration. Her request for termination of pregnancy was rejected. She later was admitted, near term, in a comatose state due to massive hemorrhage with infarction of the pontine area of the brain. One day prior to death the patient delivered a macerated stillborn infant in bed.

One might logically conclude that the five motherless children and the decedent's surviving spouse might have preferred to preserve their family unit even if it meant sacrificing of an early embryo. In addition, of course, the stillborn fetus resulted in the same outcome as far as adding another member to the family unit. The real tragedy of the case lies in the fact that those most closely concerned were prevented from making a choice for termination of the pregnancy which would have allowed the children to keep their mother and the husband his wife. Whatever our views on elective abortion, it behooves us all to reappraise and reinterpret which pregnancies may properly be aborted under existing state statutes. In our reinterpretation of existing state statutes relative to abortions, we physicians must find answers to the following questions: How imminent must death of the woman be to qualify for termination of the pregnancy? Must she die during the pregnancy or would reasonable expectation of a shortening of her life be sufficient grounds for termination? How precise are we in predicting whether continuation of the pregnancy will cause her death or a significant shortening of her life? The tragic case above demonstrates our shortcomings in this area.

It is recognized that some physicians have valid moral and theological views which preclude advising termination of high-risk pregnancies. Thoughtful referral to other physicians, not bound by such views, may be a logical solution to this dilemma.

Some may question the author's criticism of our achievements in provision of family planning services based on the 32 inappropriate pregnancies resulting in maternal deaths. It may be argued that these 32 women actively sought pregnancy in spite of their serious and important reasons for avoiding further childbearing. Refuting this contention is data recently obtained from 148 randomly selected women who had delivered a baby in Green Bay during the calendar year 1970. Sixty-six percent of the 148 women indicated that they already had conceived one or more unwanted pregnancies.

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It appears from the above reported data that the greatest potential for further reduction of maternal deaths rests with the elimination of inappropriate pregnancies. How can we as physicians provide patients with information on which they may make an informed decision regarding further pregnancy? The author believes physicians must take on this responsibility in the same manner that they advise the patient with postmyocardial infarction or ulcer about necessary changes in activity, diet, and occupational duties. That physicians have failed to do so is abundantly clear. The reasons for our failure are not so obvious but probably related to the relative rarity of maternal deaths and the uncertainty of whether any given patient will again become pregnant. We must, in the future, routinely incorporate fertility control in health care provided women in the childbearing years.

Summary

Counseling and family planning services should be available to all patients who desire it but most urgently to those women of high parity and those having serious medical complications. Provision of such service could have prevented 32 of the last 48 maternal deaths presented in this review. □

Experience with Fifteen Thousand Consecutive Pap Smears

HERBERT F. SANDMIRE, MD
Green Bay, Wisconsin

In 1960 a cytology registry was organized in the Department of Obstetrics-Gynecology of the Beaumont Clinic in Green Bay. During the ensuing ten years, 15,000 consecutive Papanicolaou (Pap) smears were registered. Certain unanswered questions prompted the formation of the registry: What is the incidence of abnormal smears? What is the yield of carcinomas in the various classes of abnormal smears? What is the false negative rate? What diagnostic measures should be employed for patients in each class of abnormal smears? At a later date, the Department became interested in determining the incidence of carcinoma of the cervix in oral contraceptive users compared to non-users.

Materials and Methods

During the first six years, all of the smears were obtained by two gynecologists. A third gynecologist participated in the study during the last four years. The same cytologist read 95% of the Pap smears. Consultation with a pathologist was obtained for all abnormal smears. The five-class system of reporting was used as follows: Class I—negative, Class II—atypical but not suggestive of malignancy, Class III—suspicious, Class IV—very suggestive of malignancy, and Class V—conclusive of malignancy.

Many of the smears were repeats on the same patient; therefore, we are reporting on 15,000 separate smears rather than patients. This explains the decrease in the yield of abnormal smears as the study progressed over the ten-year period.

Results

The incidence of the various classes of abnormal smears is outlined in Table 1. The total yield of 34 carcinomas in 15,000 Pap smears (Table 2) is one carcinoma for every 441 Pap smears. The yield of carcinomas dropped dramatically as the study progressed, indicating that a preponderance of the smears were repeats. The yield of carcinomas was one for every 357 smears in the first 10,000 but only one for every 833 smears in the last 5,000 smears.

The histological diagnoses for the various classes of abnormal smears are listed in Tables 3, 4, 5, and 6. It was surprising to find more carcinomas in the Class II smears than in any other class of abnormal smears. It should be stated that in five of the carcinomas in patients having an initial Class II smear, a repeat smear progressed to a higher level of abnormality. In seven patients with carcinoma the Pap smear never progressed beyond a Class II.

This group represents 21% of all carcinomas discovered in the 15,000 Pap smears.

Table 1—*15,000 consecutive Pap smears: 1960–1969*

	Number Smears	Percent	Frequency
Class I	14,851	99.00	
Class II	112	.75	1:134
Class III	21	.14	1:714
Class IV	10	.07	1:1500
Class V	6	.04	1:2500
Total	15,000	100.00	1:101

Carcinomas 1:441 Pap smears

Table 2—*Total carcinomas in 15,000 Pap smears*

Diagnosis	Number Patients
Carcinoma in situ	13
Carcinoma in situ with microinvasion	8
Invasive carcinoma	13
Total	34

Table 3—*Class II Pap smears: 112*

Diagnosis	Number Patients	
Dysplasia	6	
Carcinoma in situ	7	
Carcinoma in situ with microinvasion	4	12; 10.7%
Metastatic carcinoma of vagina	1	

Table 4—*Class III Pap smears: 21*

Diagnosis	Number Patients	
Dysplasia	4	
Carcinoma in situ	6	
Carcinoma in situ with microinvasion	1	
Stage I Carcinoma of cervix	1	9; 43%
Carcinoma endometrium	1	

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Table 7 illustrates the number of patients subjected to coldknife conization, in each class of abnormal smears, and the yield of carcinomas in patients undergoing this surgical diagnostic procedure. The overall yield of carcinomas in patients selected for conization was 22 of 39, or 56%.

Table 8 illustrates the negative association of the incidence of carcinoma of the cervix and the use of oral contraceptives. The incidence range reported results from retroactive study of every 100th patient to determine if she had been using oral contraceptives at the time the smear was obtained. The figures given are true for a 95% confidence limit.

A true-false negative rate can be determined only by simultaneous "smear" and biopsy. Suspicion of a false negative smear occurred in one patient with a stage II carcinoma of the cervix diagnosed 18 months after a negative smear.

TABLE 5—*Class IV Pap smears: 10*

Diagnosis	Number Patients	
Dysplasia	0	
Carcinoma in situ	0	
Carcinoma in situ with microinvasion	3	
Stage I Carcinoma of cervix	4	9; 90%
Stage II Carcinoma of cervix	1	
Stage III mesothelial Carcinoma	1	

TABLE 6—*Class V Pap smears: 6*

Diagnosis	Number Patients	
Dysplasia	0	
Carcinoma in situ	0	
Carcinoma in situ with microinvasion	0	
Stage I Carcinoma of cervix	2	
Mesonephric Carcinoma of cervix	1	4 of 5; 80%*
Recurrent Carcinoma of cervix	1	

*One patient refused biopsy.

TABLE 7—*Cold-knife conization*

	Number Smears	Carcinoma	Conization	Carcinoma on Conization	Percent
Class I	14,851	0	0	0	0
Class II	112	12	17	11	65
Class III	21	9	16	7	44
Class IV	10	9	5	4	80
Class V	6	4	1	0	0
Total	15,000	34	39	22	56

TABLE 8—*Incidence of carcinoma of the cervix in users and non-users of oral contraceptives*

11,040 to 12,960 Not on oral contraceptives	
28 Carcinomas; 1:394 to 1:463	
2,040 to 3,960 On oral contraceptives	
6 Carcinomas; 1:340 to 1:660	

Comment

There has been increasing interest in use of the colposcope to decrease the number of conizations required. Our incidence of negative conizations was 17 out of 39, or 44%. In addition, 8 of the socalled negative conization patients had dysplasia and thus received therapeutic benefit from the procedure. This leaves only 9 unnecessary conizations in the total study of 15,000 Pap smears. We believe this to be a small price to pay for accurate diagnosis of 34 carcinomas. Three patients were subjected to conization during pregnancy and an additional four became pregnant subsequent to conization. All seven had uncomplicated labors and deliveries.

The large number of carcinomas discovered in patients with Class II (less than suspicious) smears was a surprise and warrants emphasis. Figge et al[1] have recently reported similar findings. They believe that it is due to the frequently coexistent dysplasia that accompanies the early preclinical malignancy discovered in patients subjected to repeat Pap smears.

Diagnostic measures were designed to: discover all carcinomas present, keep diagnostic surgical procedures to a minimum, and provide accurate diagnosis eliminating the possibility of under-treatment of invasive lesions and over-treatment of less serious lesions. Our present diagnostic procedures employed in patients with various degrees of abnormality in their Pap smears are as follows:

Class I: Repeat annually or sooner if abnormal bleeding is experienced.

Class II: Correct vaginitis if present; repeat Pap in 6 to 8 weeks. If the repeat smear is negative, the smear is repeated in six months and then annually. If the repeat smear is Class II, a four quadrant Lugol's directed office punch biopsy is performed. If dysplasia or carcinoma in situ is diagnosed on punch biopsy, a cold-knife conization is performed. If the repeat smear is higher than Class II, a direct conization is performed without preliminary punch biopsy. There was a 65% yield of carcinomas in the Class II smear patients subjected to conization. Of all patients having an initial Class II smear 10.7% had carcinoma.

Class III: Lugol's directed office punch biopsy is done if a gross lesion is present. A cold-knife conization is performed if no gross lesion is present. There was a 44% yield of carcinoma in Class III smear patients subjected to conization. Of all Class III smear patients 43% had carcinoma.

Class IV: The procedure is the same as in Class III except a gross lesion is more common. There was an 80% yield of carcinomas in patients having conization. Of all Class IV smear patients 90% had carcinoma.

Class V: The same diagnostic procedures are employed as in Class IV smear patients. Of our Class V smear patients 80% had carcinoma.

Treatment of carcinoma in situ and carcinoma in situ with microinvasion consisted of total hysterectomy with removal of a generous portion of vaginal cuff. If the patient desired preservation of her childbearing ability, the hysterectomy was deferred so long as the follow-up Pap smears remained normal. The wisdom of advising hysterectomy for treatment of carcinoma in situ is demonstrated by the finding of residual carcinoma in situ in the hysterectomy specimen in five patients and the recurrence of carcinoma in situ in one patient treated with conization only.

ACKNOWLEDGMENT: The author wishes to thank J. Herbert Huddleston, College of Environmental Sciences, University of Wisconsin–Green Bay, for statistical analysis; and MDs S. D. Austin and J. W. Utrie, Department of Obstetrics–Gynecology, Beaumont Clinic, Green Bay, for contributing some of the Pap smears.

Conclusions

Thirty-four carcinomas were discovered in 15,000 consecutive Pap smears. Twelve of the carcinomas were in patients with atypical (Class II—less than suspicious) Pap smears.

The diagnostic measures employed resulted in a very low negative conization rate. In addition, pregnancies occurring subsequent to conization were normal in four patients and progressed satisfactorily in three patients subjected to conization during pregnancy. Our experience indicates that orderly diagnosis of cervical lesions can be achieved without the use of a colposcope; also, that the use of oral contraceptives does not increase the incidence of carcinoma of the cervix.

REFERENCE

1. Figge DC, Bennington JL, and Schweid AI: Cervical cancer after initial negative and atypical vaginal cytology, *Amer J Obstet & Gynec* 108:422, 1970. □

Radiation Reactions in Cervical Cancer Therapy

D A BUCHLER, MD et al, University of Wisconsin Medical School, Madison, Wis: *Am J Obstet Gynecol* 111:745–750 (Nov 15) 1971

Through the years, attention has been devoted intermittently to complications secondary to radiation therapy for carcinoma of the cervix. Even with improved dosimetry, it was still apparent that some patients had no problems, while others required the treatment plan to be altered because of adverse symptoms. For nine years this institution administered high-dose therapy in hopes of improving survival rates without increasing morbidity. Between January 1, 1961 and June 30, 1969, there were 410 patients treated for invasive squamous cell carcinoma of the cervix with either intracavitary therapy alone or in combination with external radiation. Those problems that developed one month post treatment or later have been discussed in a previous article and are referred to as complications. Our concern here were reactions which involved symptoms occurring during the treatment as well as one month after completion of radiation. The intracavitary dosage was determined by scintillation probe readings in the bladder or rectum. These patients received 6,000 rads to the bladder or rectum from the intracavitary applications, but the dose did not exceed 8,000 rads by combination therapy in the treatment period of 40 days.

All symptoms referable to the GI and GU symptoms were coded for each patient. The severity of these reactions were subdivided into mild, moderate, and severe to see what relationship, if any, existed between the various reactions and complications. A mild radiation bowel reaction (RBR) was considered to be a patient with 6 or more loose stools per day for one to three weeks while taking medications. A moderate reaction included the above criteria being present longer than three weeks; when the treatment was altered the symptoms were felt to be severe. Urinary symptomatology was evaluated in a similar manner.

Out of the total patients included in this series, 149 patients developed either a bowel or urinary reaction. There were 66 patients with a mild RBR, 82% had transient symptoms and subsequently had no complications, while 18% progressed with some GI complication. A smaller number of patients, 46, had a moderate RBR; out of this group, 56% remained asymptomatic, but 44% developed a GI complication. Severe RBR was observed in 15 patients; 40% of this group developed a complication. There were 24 patients, 38%, with no apparent GI reactions who later developed bowel complications.

There were so few patients with urinary reactions that a significant correlation was not seen between reactions and complications. The largest group consisted of 41 patients who had no reactions but later presented with a GU complication.

From this study, there seems to be a relationship

Ectopic Production of Prolactin

R W TURKINGTON, MD, University of Wisconsin Medical Center, Madison, Wis: *New Eng J Med* 285: 1455–1457 (Dec 23) 1971

The recognition of syndromes associated with the ectopic production of hormones has represented an important advance in the care of patients, for such hormonal effects may represent an early sign of the presence of occult carcinoma, and ectopically-produced hormones may induce major complications which require intensive therapy. Instances of the production of one or more hormones by neoplasms have been reported for nearly all the major polypeptide hormones. However, the ectopic formation of prolactin by a neoplasm has not been previously recognized. A new and highly sensitive and specific bioassay was employed to demonstrate high serum levels of prolactin in association with the presence of carcinoma in two patients.

Markedly elevated serum prolactin levels were observed in one patient with undifferentiated bronchogenic carcinoma and in a second patient with galactorrhea and hypernephroma. Irradiation of the bronchogenic carcinoma was associated with a decrease in the serum prolactin concentration from 100 to 20 ng/ml, and surgical resection of the hypernephroma reduced the serum prolactin concentration from 150 ng/ml to < 2 ng/ml. Production of prolactin was directly demonstrated in tissue cultures of the hypernephroma. The prolactin activity was found to be identical to authentic prolactin by its biological activity on organ cultures of mammary gland and by the specificity of its immunological reactivity with anti-prolactin antibodies. These studies are the first demonstration of the ectopic production of prolactin by human cancer cells, and the results suggest that carcinoma should be considered in the differential diagnosis of patients who present with galactorrhea or hyperprolactinemia. □

between radiation reactions and subsequent complications involving the GI tract. These data show an increase in the number of GI complications as the severity of the reactions became worse. Whether altering therapy would help prevent problems later is not known, but it certainly seems that complications might be decreased or in some instances avoided. However, even with close observation during treatment as well as during the post therapy period, there was still a group that developed GI complications without any previous reactions.

When reactions and complications of the GU system are studied, the same correlation is not seen. The largest group is represented by no reactions prior to developing significant complications at a later date. Because the bladder is known to be a more tolerant organ to radiation than the bowel, the percentage developing any problem is expected to be smaller.

From this data, a patient is more apt to have problems involving the GI system, and the severity of this reaction seems to be important. Although the same correlation is not seen with regards to the GU system, this may be because so few patients presented with any reactions and the majority had a complication with no preceding symptoms. However, it is felt that radiation reactions should be closely observed, since these may be symptoms prodromal to a complication. Although patients have no problems during the course of therapy, it seems a certain percentage still will develop significant complications later. □

Wanted: Case Reports of Patients Having Allergic Reactions to Biting Insects

THE FOLLOWING LETTER was received by the Medical Editor and is reprinted here in the interest of continuing medical education.

"I am compiling case reports of allergic reactions to biting insects, i.e., mosquitos, fleas, kissing bugs, bed bugs, gnats and flies—including horsefly, sandfly, deerfly. I am also interested in reactions to fire ants.

"I would like physicians to supply me with case reports of those patients who have had reactions to such insects. Include in your reports, the history of the type of reaction and complications if any; the immediate treatment; if desensitization were attempted, what were the results? Send to:

CLAUDE A. FRAZIER, MD
4-C Doctors Park
Asheville, NC 28801"

A Survey of Milwaukee Obstetricians and Gynecologists

Attitudes Toward Abortion

PAUL HALVERSON, GLORIA HALVERSON, and CLAIRE SCHEELE
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UNTIL THREE YEARS AGO, the only condition under which a pregnancy could legally be terminated in the United States was when the physical or mental health of the mother was jeopardized. In 1967 the state of Colorado liberalized its laws to also allow abortions in cases of pregnancy resulting from forcible rape, statutory rape, or incest, and in cases where a high percentage of fetal malformation could be predicted. Since this time many other states have been reconsidering their abortion legislation. As a result, the United States now has a panoply of laws on this subject which ranges from a strict limitation of abortions, as in Minnesota, to the liberal laws which permit abortion for any reason, as in New York and Hawaii. Between these extremes are variations based upon such factors as to what circumstances allow legal termination of pregnancy, what residency requirements are necessary, what the limitations are for having this procedure performed, and who is to decide if the abortion shall be done.

In 1965 a representative sample of American adults was surveyed on abortion attitudes by the National Opinion Research Center (NORC). Rossi[1] reported that this survey of almost 1,500 adults found 71% favoring abortion for medical reasons, 21% for economic reasons and about 15% for what amounted to reasons of convenience.

The opinions of physicians concerning abortion and the criteria governing its application present a similar continuum of views, with those campaigning for fetal human rights and those demanding abortion on request at the two extremes. Many surveys have been done in recent years to examine the views held by doctors concerning the liberalization of the abortion laws. A 1966 survey by Peck[2] and a similar survey by Brown et al[3] in 1970 showed that approximately 87% of physicians favor some liberalization of the abortion laws. In a Hawaii survey conducted by Smith et al[4] in 1969, 95% of responding physicians favored some type of revision of their old abortion law. In New York's survey of doctors by Hall[5] in 1965 before the new legislation was enacted, 85% of doctors favored abortion law liberalization. In California approximately 80% of physicians also favored abortion law reform (Sherwin and Overstreet[6] in 1966).

Many physicians have been placed in the awkward position of having to choose between following the letter of the law or following their own beliefs concerning abortions. It is well known that there are doctors who will perform abortions regardless of the law (up to 68% in Sherwin and Overstreet's California survey). On the other hand, there are doctors who will not perform abortions regardless of how liberal the law because of their religious or other personal beliefs. Some of the data from these surveys have been categorized and analyzed. The degree of liberalness or conservatism of physicians is often related to their age, sex, medical specialty and type of hospital affiliation. For instance, it appeared that younger men practicing at university hospitals were the most liberal.[3] The ranking from liberal to conservative responses by specialty was found to be as follows: psychiatrist, internist, pediatrician, surgeon, and then obstetricians and gynecologists. Interestingly, although the ob-gyn men have the most conservative abortion views, they are the group from which women most often seek abortions.[4]

Studies also have been conducted regarding the type of women seeking an abortion. There are variations according to age, religion, ethnic group, and income. For example, of requests received for abortions, 18.7% were from women in low income groups, 69.4% were from middle income groups, and 11.9% were from high economic groups.[4] Differences also were found in these categories in the type of patient a doctor would be most willing to abort or to offer aid in finding the proper help. Of the women in the low economic group, 72% were refused or advised against abortion while only 24% of the high income group were given this negative advice. Thus it becomes apparent that the type of patient a doctor treats may influence his attitude on abortions.

Here in Wisconsin the abortion law allowed for abortion in early pregnancy only when the mother's life was threatened. In March 1970, this law was declared unconstitutional and no new law has been proposed because the case is still being examined in the courts. In light of the relevancy of this question and the findings of surveys in other areas, we have conducted a survey to study the opinions of Milwaukee physicians concerning their attitudes

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toward abortion and some of the factors which may be affecting these opinions. This survey dealt only with the views of obstetricians and gynecologists since it has been shown that this group is the one which receives the most requests for abortions and therefore must deal most frequently with the problem.

Materials and Methods

To survey the attitudes of obstetricians and gynecologists toward abortion, a questionnaire was mailed in November 1970 to the 101 gynecologists and obstetricians listed in the Milwaukee phone directory and to the 13 obstetric and gynecologic residents at Milwaukee County General Hospital.

The questionnaire was divided into three distinct parts. The first part included pertinent questions about the doctor's background including his age, sex, religion, medical school attended, and the number of years in practice. The second part broadly characterized the doctor's patient population with questions regarding their general educational level, income, religion, and the percentage presently using birth control methods. The third section listed a series of 12 statements representing a broad spectrum of views on the abortion issue, and the physician was asked to check all of the views which he held.

After the questionnaires were returned, the responses to the various questions were tabulated. In an attempt to examine the data meaningfully, the questions were put on a scale ranging from most conservative to most liberal. The rankings were drawn from the positions presented in the medical literature, the state legislatures, and religious doctrines. The scale from the most conservative to the most liberal opinions is as follows: abortion under no circumstances, abortion when the life of the mother is threatened, abortion when the mental health of the mother is threatened, abortion in cases of incest or rape, abortion in cases of known abnormality of the fetus, abortion in cases of suspected abnormality of the fetus, abortion for socio-economic reasons, and abortion on demand of the patient.

Results

Out of the 114 obstetricians and gynecologists contacted in Milwaukee, 75 responded to the survey. This was a 66.6% return.

The questions related to abortion and the physicians' responses are given in Table 1. Forty-two percent of the respondents said that they felt the abortion laws in Wisconsin should be liberalized. The percentage of physicians who felt abortions should be given at the discretion of the physician (24%) was almost equal to the number who felt abortions should be given only with the approval of a hospital board (22.6%). On the other hand, 26.4% of the respondents believed abortions should never be given, regardless of the circumstances. Only 13.3% favored giving abortions on demand of the patient. The same number of doctors approving of abortions when the mother's life is threatened by the continuation of the pregnancy approved of abortions when the mental health of the mother is endangered (31.9%). The number of doctors that would allow abortion for socio-economic reasons is quite similar (29.9%).

The two bases for abortion that were the most frequently checked were for the reason of rape or incest, which was felt justifiable by 45.3% of the doctors, and in cases of proven fetal abnormality (also 45.3%). Where fetal abnormalities were only suspected, a lesser percentage, 38.6%, felt abortions should be allowed.

The only opinion held by a majority of responding physicians (82.6%) was that contraceptive measures should be more widely applied to help reduce the need for abortions.

The responses of these obstetricians and gynecologists were tabulated according to the information they supplied about themselves and their patient population. This data is presented in Tables 2 and 3. The disparity between the number of physicians in these categories and the total number of physicians responding to the questionnaire is present because some doctors did not answer all of the questions.

Table 2 shows the association of type of patient population with physician's attitudes. Although there were no significant differences in the physicians' opinions on abortion by type of patient that he sees, doctors of Protestant patients tended to give more liberal responses than doctors of Catholic patients. Also there is a trend for doctors to give more liberal responses as the percentage of their patients using birth control increases.

Much wider variations of responses are seen when the data are analyzed by certain sociological characteristics of the physician. These figures are presented in Table 3.

TABLE 1—*Positive responses to opinions on abortions: Milwaukee obstetricians and gynecologists, November 1970*

Question	Total Number	Percent
Contraceptive measures should be more widely applied to help reduce the need for abortions	62	82.6
Abortions should be given in cases of rape or incest	34	45.3
Abortions should be given in proven cases of abnormality (e.g. Down's syndrome)	34	45.3
Wisconsin's abortion law should be liberalized	31	42.4
Abortions should be given in cases of suspected abnormality of the fetus (e.g. rubella infection of the mother in the first trimester)	29	38.6
Abortions should be given when the mental health of the mother is endangered	23	31.9
Abortions should be given only when the mother's life is threatened by continuation of the pregnancy (present Wisconsin law)	23	31.9
Abortions should be given for socio-economic reasons (e.g. large family and low income, for population control, etc.)	22	29.9
Abortions should not be given under any circumstances	19	26.4
Abortions should be given at the discretion of the physician	18	24.0
Abortions should be given only with approval of a hospital board	17	22.6
Abortions should be given on demand of the patient	10	13.3

Since only two female obstetricians and gynecologists in Milwaukee responded, no analysis of data was done by sex.

Analysis of the doctors' attitudes towards abortion by their religion yields the largest statistically significant ($p < 0.05$) differences in opinions among doctors. When comparing the Catholic physicians' responses to those of the non-Catholic physicians, the Catholic physicians were shown to have much more conservative opinions about abortion than either the Protestant or Jewish doctors. The only exception is the question pertaining to the present Wisconsin law (life threatening) where the same percentages of Protestant and Catholic doctors agree. In addition, a large majority of the doctors responded positively irrespective of their religions to the statement that the use of contraceptives should be increased (77.5% of the Catholic doctors, 90% of the Jewish doctors, and 94.4% of the Protestant doctors).

Statistically significant differences also are seen with the majority of questions when analyzed according to whether or not the physician had graduated from Marquette School of Medicine (now The Medical College of Wisconsin). Most of the non-Marquette graduates are willing to permit abortions for many more reasons than are the Marquette graduates. For example, 74% of the non-Marquette graduates feel Wisconsin's abortion law should be liberalized, but only 22% of the Marquette graduates

TABLE 2—*Attitudes of Milwaukee obstetricians and gynecologists on abortion analyzed by characteristics of patient population: November 1970*

	Number Responding	Liberalize Wisconsin Law	At Physician's Discretion	Hospital Board Approval	Under No Circumstances	Endangered Mental Health	Life Threatening	Suspected Abnormality	Proven Abnormality	Patient Demand	Rape or Incest	Socio-economic Reasons	Increase Contraceptive Use
Education													
High School or less	40	42.0	28.9	15.8	28.9	34.2	28.9	31.6	42.0	15.8	47.4	26.3	78.9
More than high school	29	37.9	20.7	27.6	24.1	24.1	34.5	41.4	44.8	10.3	41.4	27.6	82.3
Religion													
Catholic	39	33.3	20.5	15.4	35.9	25.6	30.8	30.8	33.3	12.8	38.5	23.1	74.4
Jewish	7	47.8	14.3	14.3	28.6	28.6	28.6	42.8	42.8	28.6	42.8	14.3	57.1
Protestant	37	47.2	25.0	36.1	19.4	33.3	41.6	36.1	52.8	13.9	44.4	27.8	83.3
Income													
< $10,000	30	39.3	28.6	14.3	17.8	21.4	35.7	32.1	42.8	17.8	53.6	21.4	85.7
> $10,000	33	39.4	18.2	30.3	36.4	36.4	33.3	36.4	42.4	9.1	42.4	33.3	78.8
Birth Control Use													
1-25%	9	11.1	11.1	0	55.6	11.1	33.3	0	11.1	0	22.2	0	33.3
25-50%	11	27.3	18.2	18.2	36.4	18.2	36.4	45.5	54.5	9.0	45.5	9.0	81.8
50-75%	22	38.1	19.0	23.8	19.0	19.0	42.9	23.8	33.3	4.8	42.9	14.3	90.5
75%	30	60.0	36.7	23.3	20.0	53.3	20.0	56.7	56.7	26.7	56.7	56.7	90.0

agree with them. When the Catholic medical school graduates from Marquette are compared to the Catholic graduates from other medical schools, it is seen again that the Catholic Marquette physicians are more conservative than the Catholic non-Marquette physicians, but the difference between the two Catholic groups is not as great as the difference between Marquette and non-Marquette graduates.

Seventy-five percent of the respondents, in the over-50 age group, were in favor of liberalizing the abortion laws while all other age groups gave such proposed changes much less support (Table 3). Only 16.7% of the doctors 35 years or younger were in favor of liberalization of the law. Attitudes of the other age groups were between these two extremes with 46.7% in the 36–40 age group,

TABLE 3—*Attitudes of Milwaukee obstetricians and gynecologists on abortion analyzed by characteristics of the respondents: November 1970*

	Number Responding	Liberalize Wisconsin Law	At Physician's Discretion	Hospital Board Approval	Under No Circumstances	Endangered Mental Health	Life Threatening	Suspected Abnormality	Proven Abnormality	Patient Demand	Rape or Incest	Socio-economic Reasons	Increase Contraceptive Use
Age													
<36	13	16.7	0	25.0	25.0	16.7	33.3	25.0	41.7	0	11.7	0	83.3
36-40	20	45.0	25.0	10.0	35.0	30.0	15.0	35.0	40.0	20.0	45.0	35.0	80.0
41-45	17	35.3	47.0	11.8	29.4	35.3	29.4	35.3	41.2	11.8	47.0	35.3	76.5
46-50	15	46.7	13.3	40.0	26.7	40.0	53.3	40.0	53.3	6.7	46.7	40.0	86.7
>50	8	75.0	37.5	25.0	0	37.5	37.5	62.5	50.0	37.5	50.0	25.0	87.5
Religion													
Catholic	39	12.8	10.3	12.8	43.6	12.8	38.5	12.8	20.5	2.6	23.0	7.7	77.5
Jewish	10	90.0	60.0	10.0	10.0	70.0	0	70.0	80.0	40.0	70.0	80.0	90.0
Protestant	18	72.0	38.9	44.4	0	55.5	38.8	72.2	77.8	27.8	83.3	50.0	94.4
Years in Practice													
0-5	17	29.4	11.8	11.8	35.3	17.6	17.6	29.4	41.2	0	41.2	5.9	76.5
6-10	21	33.3	23.8	9.5	28.6	28.6	33.3	28.6	38.0	19.0	47.6	33.3	76.3
11-15	13	53.8	46.1	30.8	15.4	88.5	30.8	46.2	53.8	23.0	53.8	46.2	100
16-20	15	40.0	13.3	40.0	33.3	40.0	46.7	40.0	46.7	0	40.0	33.3	80.0
>20	6	83.3	50.0	16.7	0	50.0	33.3	66.6	50.0	50.0	50.0	33.3	83.3
Religion and Medical School													
Marquette	45	22.2	13.3	17.8	37.8	17.8	35.6	26.7	28.9	8.9	28.9	17.8	75.6
Catholic	34	6.0	8.8	11.8	47.0	2.9	35.3	11.8	14.7	2.9	17.6	6.0	73.5
Non-Catholic	11	72.5	27.2	36.4	9.2	63.5	36.4	72.5	72.5	27.2	63.5	54.5	82.0
Non-Marquette	27	74.0	44.0	26.0	7.4	55.6	25.9	55.5	70.4	22.2	74.0	48.0	92.6
Catholic	8	50.0	12.5	37.5	12.5	50.0	37.5	37.5	62.5	0	50.0	25.0	87.5
Non-Catholic	19	84.5	58.0	21.0	5.3	58.0	21.0	63.0	73.0	31.3	84.5	58.0	95.0

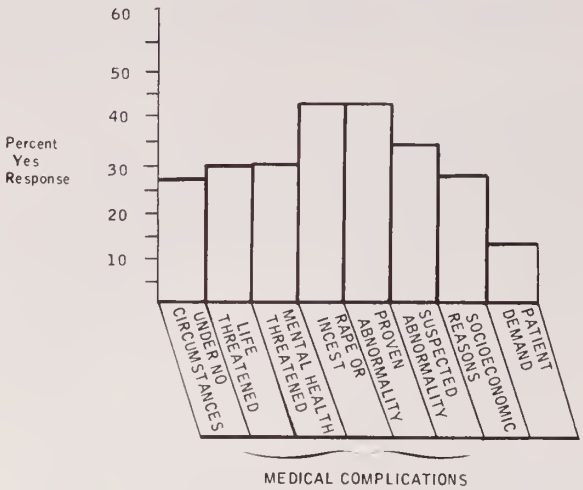

Figure 1—Opinions of Milwaukee obstetricians and gynecologists on abortion.

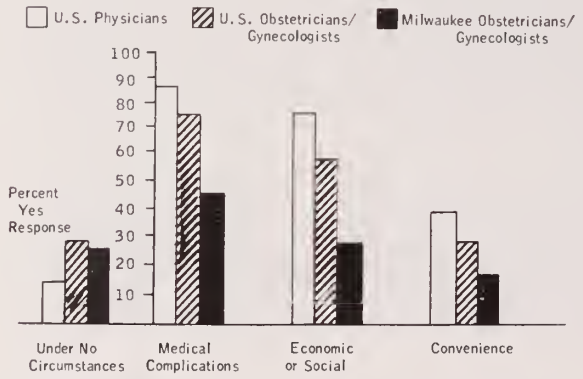

Figure 2—Comparison of opinions on abortion of Milwaukee obstetricians and gynecologists with attitudes of other physicians in nationwide survey.[3]

35.3% in the 41–45 age group, and 45% in the 46–50 age group favoring changes in the law. Response to other questions also indicated a trend for the older men to have more liberal views than the younger men. This trend is borne out when the data was analyzed according to the number of years these physicians have practiced. The doctors who have been practicing for more than 20 years, all of whom are included in the previous population of the over-50 age group, show an even greater trend toward liberalness than those with practices of shorter duration. The attitudes of those physicians who have practiced medicine for five years or less are similar to the group in the age range 35 years or younger; this appears to be the most conservative age group. This point is best illustrated by the question about allowing abortions to be given on demand of the patient. Of the doctors who had been practicing for over 20 years, 50% agree with this whereas none of the doctors in practice for five years or less agreed with this statement. In fact, the doctors with over 20 years of practice show significantly more liberal responses to this question than the physicians with any less experience.

Discussion

After examining the abortion laws of the other states and the practical, religious, and moral arguments both for and against abortions for various reasons, we have ranked the questions pertaining to abortion attitudes asked in this survey from those which are responses representing liberal views to those which are generally accepted as being conservative (see listing in Materials and Methods section). This gave us a spectrum in which various groups were placed according to their responses and thus aided our discussion of the meaning of these responses.

The distribution of responses by Milwaukee obstetricians and gynecologists according to this scale is given in Figure 1. The number of opinions concerning abortions peak in the moderate area and decline toward the extremes of the spectrum, although a higher number of doctors seem to fall in the conservative areas than the liberal areas.

In comparing the attitudes of the obstetricians and gynecologists in Milwaukee to those physicians elsewhere in the United States, the respondents to this survey seemed much more conservative (Fig 2). Obstetricians and gynecologists throughout the country seem to be a more conservative group as a whole when compared to all physicians, but those in Milwaukee are significantly more conservative than the other ob-gyn men.

The conservative attitudes of the Milwaukee physicians surveyed do not seem to be associated with characteristics of their patients since none of the comparisons between the doctors' responses and the patients' age, income, educational level, and religion showed statistically significant differences.

The religious beliefs of the Milwaukee physicians seem to be the most discriminating factor in determining the physicians' attitudes toward abortion. While only 42% of the ob-gyn men surveyed in Milwaukee felt that the abortion law in Wisconsin should be liberalized, it also should be remembered that more than half of the obstetricians and gynecologists were Catholics. As illustrated in Figure 3, the Catholic physicians show a steady decrease in the number of positive responses to questions that represented increasingly more liberal views. The Catholic Church has placed abortion in the category of murder and this seems to be associated with the

doctors' attitudes and moral standards. The views of the Protestant doctors surveyed show them to be much more liberal than their Catholic counterparts (Fig. 3). Distribution of their answers fairly well follows that of the doctors polled nationally but with slightly more variation for the individual questions. This variation might be attributed to the fact that there is much variation in the tenets upheld by different denominations within Protestantism. The physicians of the Jewish faith overall gave consistently more liberal responses to the questions on abortion attitudes than the other two religions.

Although the Catholic Church has taken a strong stand against contraception, the Protestant and Jewish faiths have not. Interestingly, 77.5% of the Catholic doctors favor increased use of birth control methods. Although this percentage is less than the percentage for either Protestant or Jewish physicians, this is still an indication that, while religion plays a major role in a doctor's decision-making process, many other factors significantly modify his attitudes.

When the background influences upon these doctors are examined, it is interesting to note the differences in attitude with age and years in practice. Although older people are generally considered to be less liberal than those younger, this idea is not borne out in this study. In fact the opposite is true; the older doctors gave the more liberal responses. This is seen most clearly in the responses to the question of abortions being given on demand of the patient. While 50% of the doctors practicing over 20 years (all of whom are over 50 years of age) agreed that abortions should be performed under these circumstances; none of the doctors in practice for five years or less held this liberal opinion. This trend with age holds regardless of the physicians' religion.

This study also points out the differences between the attitudes of doctors who graduated from Marquette School of Medicine and the attitudes of those who attended other medical schools and are practicing in Milwaukee. Figure 4 illustrates that the general pattern of attitudes of the non-Marquette graduates parallels that of the doctors surveyed nationally. However, even after the data was standardized for religion, the Marquette graduates tend to be more conservative in their responses. This suggests that there are other factors inherent in Marquette medical school graduates other than religion which lead to their responses. This may possibly stem from the type of person choosing to attend this school or the atmosphere of the training program.

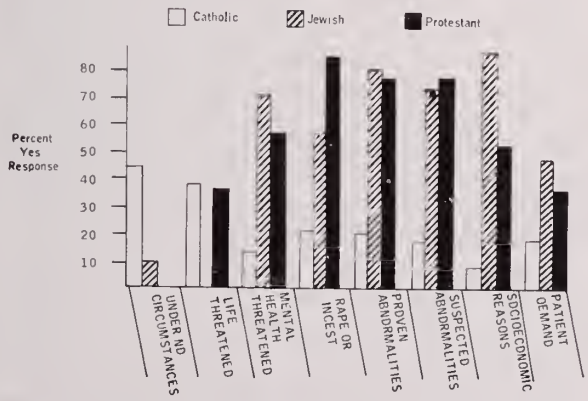

Figure 3—Attitudes of Milwaukee obstetricians and gynecologists on abortion as influenced by their religion.

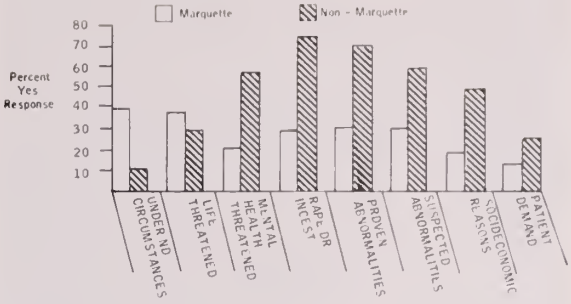

Figure 4—Opinions of all Milwaukee obstetricians and gynecologists as influenced by medical school attended.

One of the other points to be considered is the response to the question of wider application of contraceptive measures to help reduce the need for abortions. Of the physicians surveyed, 83% agreed that more contraception should be attempted, representing by far the largest positive response given to any of the survey questions. There were only 13 doctors who did not feel the statement favoring larger application of contraceptive measures reflected their views. All 13 of these physicians also were not in favor of liberalizing the Wisconsin abortion law. In fact, 11 of these 13 felt no abortion should be allowed regardless of the circumstances. The stand of these doctors concerning contraception, therefore, seems to be an extension of the very conservative philosophy to which they adhere.

After reviewing many of the possible factors that play a part in the shaping of a doctor's decision regarding abortions, it is clear then that there are many factors intricately woven together and each factor is not as important to the same degree for each physician. However, some influences do stand out as being crucial to the attitude-forming process, especially the influence of religion.

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Comments on Treatment

Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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Colles' Fracture

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In the 1814 *Edinburgh Medical and Surgical Journal,* Abraham Colles published an article "On the Fracture of the Carpal Extremity of the Radius."[1] Since then the spectrum of forces producing injury to the distal radius has widened, and the resulting fractures may be more complex, but the challenge today is much the same that Dr. Colles faced, namely, recognizing the extent of the injury, reducing the fracture, maintaining the reduction until healing occurs, and avoiding the pitfalls which lead to poor results.

Dr. Colles described the fracture as occurring one and one half inches above the carpal extremity of the radius. We now include virtually all fractures of the distal two inches of the radius under the name "Colles' fracture." These are the most common fractures of the long bones.

The mechanism of injury is a fall on the outstretched arm. With the hand fixed, the momentum of the body is transmitted through the forearm. A supination moment is created between the brachioradialis and pronator quadratus, producing maximal stress where cortical bone blends into cancellous bone in the distal radius. With structural failure, the distal fragment angulates posteriorly and radially. Longitudinal force produces impaction of the fragmented cancellous bone, but unopposed supination allows the distal fragment to displace posteriorly. The summation of anterior swelling, radial deviation, and an abrupt posterior prominence is described as a "dinner fork deformity." Instability, pain and ecchymosis will be inversely proportional to the impaction. Increasing deformity and swelling will jeopardize the functional integrity of the flexor tendons, the median and ulnar nerves, and the radial artery.

Physical examination should screen the injured extremity for associated injuries of the hand, proximal forearm, elbow, humerus, shoulder and clavicle, and should document the deformity of the wrist. The presence of the radial pulse, and median and ulnar nerve function should be recorded. Rings present on any finger should be removed immediately. The patient's general medical condition should be determined. The time of the last oral intake should be noted, as it may be a factor in determining the type of anesthesia to be used for the reduction.

Adequate x-ray views should be taken to document the injury, and to be sure that no associated injuries are overlooked. Anteroposterior and lateral

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Figure 1—Anteroposterior x-ray view of a typical Colles' fracture.

Figure 2—Lateral x-ray view of a typical Colles' fracture.

views should include the carpus and the entire forearm. If a ring is seen on the x-ray films, its removal should be delayed no longer. Figure 1 is the anteroposterior view of a typical Colles' fracture. The distal fragment is displaced proximally and radially. Supination contributes to the apparent enlargement and rotation of the fragment. The distal radio-ulnar joint is disturbed. Figure 2 is the lateral x-ray film of the same fracture. The distal fragment angulates posteriorly. There is moderate posterior comminution and displacement.

The x-ray films are used to determine whether reduction is necessary, how it should be accomplished, and how difficult it will be to maintain the reduction. If no displacement or angulation is present, no reduction is necessary. However, during the course of healing, there will be resorption of the ends of the fragments. Such resorption may allow loss of position, and should be prevented by applying a long arm cast with the wrist in mild flexion, ulnar deviation and pronation.

If significant displacement, angulation or rotation is present, the position is not acceptable. If comminution is not severe, closed manipulative reduction is usually successful. Adequate anesthesia is mandatory for the reduction, otherwise the patient will tense muscles in response to pain and the reduction may be lost, or never achieved.

Manipulation should strive to restore anatomic alignment of the fragments. Impaction should be disrupted by gentle, continuous traction and countertraction. Once the impaction has been disrupted, the posterior displacement should be corrected by the manipulator's thumb pushing the fragment into place while using the fingers anteriorly as a fulcrum. If this is not successful, the deformity should be increased to 90 . Then the distal fragment can be brought into the correct position using the edges of ths proximal fragment as the fulcrum. Once the displacement has been corrected, the posterior angulation is corrected by flexion, radial deviation is corrected by ulnar deviation, and supination is corrected by pronation. Pronation also tightens the posterior wrist ligaments and locks the fragments into place. Unless there is severe comminution, the reduced position should be stable. If the reduction seems satisfactory by palpating the bony landmarks, a posterior splint should be applied to maintain the position. Careful molding of the splint along the radial border of the second metacarpal can protect the proper amount of flexion and pronation while preparing for definitive immobilization.

Post-reduction x-ray films should be taken to confirm the reduction. The tip of the radial styloid should be one centimeter distal to the ulnar styloid, and the distal radial articular surface should face ulnarward 30 on the anteroposterior x-ray. On the lateral view, the distal articulating surface should face anteriorly 15 . Less than optimal position may be accepted, especially if there is posterior comminution. One may accept anterior angulation to neutral, 0 , but dorsal angulation is generally not acceptable and inadequate ulnar deviation, less than 10 , will interfere with function of the distal radio-ulnar joint. If the position of the fragments is not acceptable, the splint should be removed to allow remanipulation until either an acceptable position is achieved, or reduction appears to be hopeless.

If the alignment is acceptable, and little or no swelling is present, a definitive long arm cast may be applied, incorporating the splint without disturbing the reduction. If the swelling is moderate to severe, an anterior splint should be applied, and should be held firmly with gauze. As the edema subsides, the splints may be tightened by the judicious use of elastic bandages. If, at any time, the circulation is compromised by a cast or splint, pressure must be released by splitting the cast or releasing the dressings, even to the point of sacrificing the reduction, in order to restore adequate circulation. When the swelling has subsided, the definitive cast should incorporate the elbow to prevent pronation and supination. The cast should not extend beyond the palmar flexion crease and should allow 90° of flexion at the metacarpophalangeal joints of all the fingers. Posteriorly the cast should extend to the metacarpal heads. Too short a cast will allow edema of the hand.

Following reduction, the patient should elevate the forearm until the swelling subsides. The cast or splints should be observed closely during this time to be sure that there is no circulatory impairment. The patient may use a sling for comfort, but should put the shoulder through a full range of motion at least four times a day. The fingers should be put through a 90° range of motion at all three joints at least four times a day. During the first three weeks after the fracture, the reduction should be checked by x-ray every 7 to 10 days. As the swelling subsides, the immobilization may become less secure, and the position may change. If the reduction becomes unacceptable, the fracture should be remanipulated until an acceptable position has been obtained. If maintaining the reduction proves difficult, K-wires may be introduced under sterile conditions to give internal fixation. These K-wires may be placed longitudinally, transversely, and/or obliquely for stabilization, with the most helpful placement being perpendicular to the vector of displacement. After three weeks from the time of the injury, the fragments rapidly become less mobile, either for displacement or for correction, and the definitive position should have been accomplished by this time. After four weeks from the time of the injury, the fracture will be stable enough to allow removal of the cast above the elbow, and the patient should begin vigorous elbow range of motion exercises. After six to eight weeks from the time of the injury, bony trabeculae should be visible crossing the fracture line. Healing now is sufficient to allow cast removal and the initiation of a program of skin cleansing and wrist range of motion exercises. No exercise should cause pain, and no form of passive manipulations should be used.

If the fracture was severely comminuted or if it has proven to be so unstable that acceptable alignment cannot be maintained by splints or casts, the best course of treatment is to place the patient in skeletal traction. K-wires should be placed through the bases of the second and third metacarpals, taking care to avoid damage to the interosseus muscles or the flexor and extensor tendons. Countertraction can be applied through a K-wire in the olecranon. Repeated gentle manipulations may bring the fragments into excellent position which can be maintained by the traction with relative ease. When the fragments no longer move freely, a long arm cast can be applied, incorporating the K-wires. This cast immobilization should be maintained until healing is demonstrated.

The prognosis is related to the excellence of the reduction, not to the age of the patient nor to the methods of reduction or fixation. The functional result is also proportional to the degree of diligence with which the patient has worked to maintain finger and shoulder motion. Far more disability will come from stiff fingers than from a stiff wrist.

Even if all potential complications are prevented, or recognized and treated aggressively, there seems to be an almost inevitable tendency for some loss of reduction during the healing, especially in comminuted fractures. At times this loss of position is so severe that the fracture heals in a position not too far removed from the unreduced fracture. Dr. Colles made an interesting observation on this point when discussing poorly treated fractures. "One consolation only remains, that the limb will at some remote period again enjoy perfect freedom in all its motions and be completely exempt from pain; the deformity, however, will remain undiminished through life."[1]

In 1953 Bacorn and Kurtzke[2] analyzed 2,000 cases from the New York State Workmen's Compensation Board, and found that an average of 24% disability of the arm was awarded following Colles' fracture. We should strive to reduce this figure through better understanding of the mechanism of injury, and more attention to the details of care in the treatment of the fracture. Then it may be said of our results as Dr. Colles said for his, "the cases treated on this plan have all recovered without the smallest defect or deformity of the limb, in the ordinary time for the cure of fractures."

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Case of Primary Adenocarcinoma of the Vermiform Appendix

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CARCINOMA OF THE APPENDIX is extremely rare and should not be regarded as a low-grade malignancy. It should be treated aggressively like any other carcinoma of the colon or gastrointestinal tract. Although found in all age groups, it is most common between the ages of 40 and 65 years and has no sex predominance. The youngest reported patient was 17-years old. Carcinoma of the appendix is found in 0.2 to 0.4 percent of all removed appendices and constitutes only 0.3 to 0.4 percent of all intestinal tumors.

The site of predilection is usually at the base or proximal third of the appendix and may be ulcerative or polypoid. It is spread by invasion of the lymphatic and venous channels and may involve the liver, peritoneum, and even the lungs.

The first case of adenocarcinoma of the appendix was reported by Bayer in 1882, although Marlin in 1838 and Rokitansky in 1867 had described primary tumors of the appendix.

From 1960 to 1970, 577 appendices were removed at Memorial Hospital, Neillsville, Wisconsin. One hundred and seventy-three patients had incidental appendectomies and 404 had a preoperative diagnosis of acute appendicitis. In this series only one patient was found to have adenocarcinoma of the appendix. There was one appendix with mucocele and three patients showed endometriosis affecting the appendix. One patient with endometriosis had marked anemia, and a barium enema showed an indentation of the base of the appendix at the cecum.

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Pathology

Sieracki and Tesluk[1] proposed a simple classification of tumors of the appendix: (1) noninvasive—the lesion is confined to the mucosa, and (2) invasive—the lesion extends beyond the mucosa. However, Uihlein and McDonald[2] described three varieties of tumors of the appendix: (A) Carcinoid (88.2%)—a yellow tumor which has a little tendency to metastasize but which may invade the local area extensively. (B) cystic (8.3%)—the appendix contains gelatinous material or the ruptured appendix is associated with pseudomyxoma peritonei. Although the peritoneal implants are metastatic, lymph nodes are rarely involved and there are no distant lymphatic or blood-borne metastases. (C) Colonic (3.5%)—these are similar to adenocarcinoma of the colon and they may spread by direct extension or by lymphatic or blood vessel invasion.

Clinical Manifestations

The clinical manifestations are similar to that of acute appendicitis with the symptoms occurring as a result of obstruction of the lumen of the appendix by the tumor, involvement of the appendix by infiltration with marked inflammatory changes on the wall with or without any perforations. If there is perforation, an early spread to the peritoneum will result. Also it causes obstructions to both vascular and lymphatic routes. It is quite difficult to clinically differentiate between acute appendicitis and that of adenocarcinoma of the appendix even with the aid of such diagnostic measures as x-ray, blood or enzyme studies.

Diagnosis

Diagnosis is usually established by the pathologist. However, diagnosis also can be made if the surgeon suspects the lesion to be adenocarcinoma and a frozen section is obtained. If the cecum is involved and preoperative barium enema studies show a defect at the base of the appendix with lack of physiologic function of the appendix, the conditions also may be suspected.

In Hesketh's[3] series 19 patients had simple appendectomy. Fourteen of these (75%) died of the disease in the first five-year period; 31 patients had right hemicolectomy, and 10 of these (35%) died within the five-year period; 19 (63%) survived five years or more including two (8%) who exceeded the ten-year survival period.

In any operation of the appendix this disease entity should be considered, and frozen sections should be made if suspicion of cancer arises.

Treatment

It is now a standard procedure to perform a radical right hemicolectomy about two weeks after appendectomy for all patients except where lesion was confined to the mucosa. Other surgeons recommend doing a bilateral oophorectomy at the time of the right hemicolectomy because of frequent metastasis to the ovaries. If the lesion is suspected at the time of the operation and proven by frozen section, the right hemicolectomy should be done.

Case Report

A 71-year old Caucasian man was admitted to the hospital complaining of abdominal pain localized in the right lower quadrant.

The present illness started about four days prior to his admission when he started having vague abdominal pain, low-grade fever, and loss of appetite. On the day of his admission he claimed that the abdominal pain was gradually getting worse and then seemed to be more localized over the right lower quadrant. He denied any nausea, vomiting, constipation or diarrhea. The patient was taking Raudixin,® 100 mg daily, for hypertension. He had no previous serious illness or surgery. Physical examination was essentially negative except for the abdomen wherein the patient was obese and soft with tenderness to palpation over the right lower quadrant. The bowel sounds were present and hypoactive. The liver, spleen, and kidneys were not palpable. Rectal examination was negative.

LABORATORY: The white blood cell count was 14,600 per cu mm with 66% segmented forms and 5% stabs. The remainder of the blood count, urinalysis, blood urea nitrogen, fasting blood sugar, ECG and chest x-ray film were all reported normal. Stools for occult blood were taken on three successive days and only a trace of blood was noted. Barium enema showed failure to adequately distend the cecum on two attempts as described by the radiologist. The tip of the cecum appeared to be indented and apparently shortened and the mucosal pattern was intact. The rest of the colon was reported entirely negative.

Four days after his admission the patient underwent exploratory laparotomy and a low right paramedian incision was made. The appendix was markedly distended, indurated, and had perforations at the base. The perforated area was covered with white exudate. Grossly it had the appearance of a subsiding acute appendicitis. The appendix was removed and the base of the appendix was approximated with some difficulty. The abdomen was closed with drains in the right lateral gutter and pelvis.

PATHOLOGY REPORT: Grossly the appendix was about 6.0 x 0.6 cm. The surface was hemorrhagic. The microscopic examination showed it was lined by anaplastic epithelium and irregular glandular formation that had invaded the wall of the appendix as far as the serosal layer. There was marked inflammatory reaction to the invading tumor. Sections of the distal end of the appendix revealed the lumen was obliterated by fibrous tissue and showed inflammatory changes. The pathological diagnosis was mucous-secreting adenocarcinoma of the appendix, grade II, class B.

POSTOPERATIVE COURSE: The patient did well postoperatively and was discharged one week after surgery. Two weeks later the patient was readmitted for right hemicolectomy and transverse ileocolostomy. His postoperative course again was good and he was in the hospital three weeks.

Nine months later the patient was seen for a follow-up study. He had been feeling good and gaining weight. Barium enema was done and it was negative for recurrence of tumor in the large bowel.

After another six months the patient was again admitted to the hospital complaining of tiredness, generalized weakness, dizziness, and shortness of breath. The physical examination was unremarkable except that the conjunctivae were very pale. Rectal examination and sigmoidoscopy examination were negative. The laboratory reported 6.6 gm of hemoglobin and a hematocrit reading of 18 vol.% and the red corpuscles were hypochromic. Bilirubin (indirect, direct and total), SGOT, LDH, thymol turbidity, cephalin flocculation, serum cholesterol, total proteins, albumin, globulin, A:G ratio, alkaline phosphatase were all reported normal. Stools for occult blood on three successive days were positive for blood. Blood sugar, blood urea nitrogen, uric acid, Ph, PCO2, H2CO3, HCO3, Na, K, and Cl were all within normal limits. The patient was given four units of packed cells and a repeat hemoglobin was 11.9 gm and the hematocrit reading of 36 vol.%.

Barium enema again was done and showed a normal postoperative colon without any evidence of disease. An upper gastrointestinal x-ray study was normal except for a diverticulum in the third portion of the duodenal loop. A chest x-ray film was reported as normal.

The patient was discharged after a week in the hospital. However, three weeks later (now about 16 months since his original admission) he was seen again complaining of fatigue. He continued to have bleeding in the gastrointestinal tract as evidenced by positive occult blood in the stool and also the decreasing hemoglobin. Consequently a laparotomy with gastrotomy followed by 75% gastric resection (Billroth II, anticolic) was carried out when a bleeding ulcer in the first portion of the duodenum was found. Also resection of a tumor in the mid ileum with end-to-end anastomosis was done.

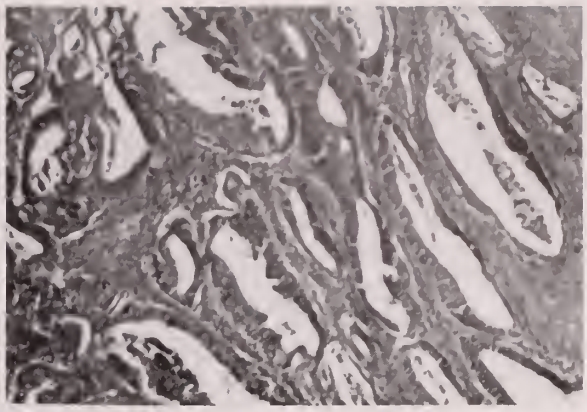

Figure 1—Section of the appendix lined by the anaplastic epithelium with irregular glandular formation invading the serosal layer.

On the eighth postoperative day there developed abdominal distention, vomiting, and acute renal insufficiency. The serum creatinine and the blood urea nitrogen were markedly elevated and fine moist rales were heard in the lung bases. The patient died on the 14th postoperative day from acute renal insufficiency. Post mortem examination was not obtainable. The gross microscopic and pathological reports: The segment of the stomach measured along the lesser curvature about 9.0 cm and along the greater curvature 17.0 cm. Across the amputated distal end, it was 2.0 cm wide and at the proximal end about 7.5 cm wide.

A section of small bowel was 6.0 x 3.0 cm. There was a puckered area in the center completely encircling the bowel. In this area, the bowel was slightly ulcerated and the wall was thickened over a distance of about 7.0 to 8.0 cm. Microscopic examination of sections of the stomach revealed no atypicalities. Sections of the ileum revealed anaplastic tumor cells in the glandular and tubular formations infiltrating the entire thickness of the wall of the bowel and extending into the serosa. There was a marked desmoplastic reaction around the invading tumor. The lining mucosa was ulcerated over the focus of the tumor. The focus of tumor appeared to involve the submucosa muscular wall as much as the surface epithelium. It had a roughly ovoid appearance and appeared more characteristic of a secondary or metastatic growth rather than a primary.

Review of sections from the original surgery revealed that the primary tumor in the appendix was reported at that time as a similar morphology to this tumor in the ileum. This tumor would be best explained as a metastatic tumor in the ileum having originated from the primary site in the appendix.

Summary

The case presented was that of an elderly Caucasian man who had undergone appendectomy for what appeared grossly to be a subsiding acute ap-

pendicitis and confirmed by the pathologist as adenocarcinoma of the appendix. The patient had undergone right hemicolectomy two weeks later and did nicely until about 20 months later when he started having bleeding in the gastrointestinal tract and underwent exploratory laparotomy. He died two weeks postoperatively from acute renal insufficiency.

The age incidence, the sites of predilection, which are the base and the proximal third of the appendix, and the clinical manifestation of the obstructive symptoms to the appendix are very typical of the case presented.

The prognosis depends on whether the appendix is ruptured or perforated and if the tumor is limited to the mucosa. It is difficult to diagnose adenocarcinoma of the appendix preoperatively. The treatment of choice is right hemicolectomy depending on whether or not the tumor was confined to the mucosa.

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Simplified Hemagglutination Test for Farmer's Lung

F J WENZEL, BS, D A EMANUEL, MD and R L GRAY, BS, Marshfield Clinic Foundation, Marshfield, Wis: *Am J Clin Pathol* 57:206–208 (Feb) 1972

Control sera were obtained from 40 individuals with no history of exposure to moldy forage, and precipitin-positive sera from 40 farmers with clinical and biopsy evidence of farmer's lung.

One-half milliliter of packed, washed, sheep erythrocytes was completely suspended in 1.0 ml of physiologic saline solution containing 1.0 mg of the antigen (extracts of *M. faeni* and *T. vulgaris*). While the tube was slowly rotated by hand, 1.0 ml of 0.1% chromium chloride in physiologic saline solution was added. After five minutes at room temperature, the cells were washed with 20 volumes of physiologic saline solution and centrifuged at 1,000 rpm for one minute. The wash was repeated three more times and the cells adjusted to a final concentration of 1.0% in physiologic saline solution for the test.

The passive hemagglutination test was performed by a macrotiter method (a microtiter method may also be used). Starting with an initial 1:2 dilution, serial twofold dilutions of the patient's serum were made in physiologic saline solution so that 0.1 ml remained in each tube. After one hour at room temperature, the tubes were centrifuged for one minute at 1,000 rpm. The end point was expressed as the reciprocal of the highest dilution of test serum that produced complete agglutination of the 1.0% suspension of sensitized sheep cells.

Three controls were used. The negative control contained sensitized sheep erythrocytes in a known negative human serum. The second contained nonsensitized sheep erythrocytes in known farmer's lung serum. The third contained sensitized sheep erythrocytes in serum previously demonstrated to have farmer's lung hemagglutinating antibodies.

Of 40 normal persons without evidence of circulating antibody by the agar gel diffusion test, none had hemagglutination tests that were positive. Of the 40 patients with precipitins to *M. faeni,* 36 had hemagglutinating antibody titers between 1:4 and 1:256. Of four individuals sensitized to *T. vulgaris* and tested with an extract of *T. vulgaris* as the antigen, all had positive precipitin and hemagglutination tests, the titers ranging from 1:4 to 1:64.

The hemagglutination test is simple and can be performed in slightly more than one hour. □

The Importance of Six Common Bacteria in Intestinal Strangulation

C E YALE, MD, DSc, and EDWARD BALISH, PhD, University of Wisconsin Medical School, Madison, Wis: *Arch Surg* 104:438–442 (Apr) 1972

The effect of monocontamination by each of six common intestinal bacteria was studied in germfree rats with ischemic or hemorrhagic closed loop intestinal strangulation. We found that (a) *Bacteroides fragilis, Streptococcus faecalis,* and *Lactobacillus acidophilus* were innocuous, (b) *Staphylococcus aureus* 80/81 killed 17% of the animals; and (c) *Proteus vulgaris* and *Pseudomonas aeruginosa* killed more than 90% of the rates within 36 hours after strangulation. We concluded that the common intestinal bacteria vary greatly in their ability to cause death after strangulation. It is hoped that a better understanding of the relative importance of the intestinal bacteria will enable the clinician to more rationally choose the antibiotics necessary to treat the septic phase of strangulated intestinal obstruction. □

Pneumocystis Pneumonia and Disseminated Histoplasmosis in Association with Hodgkin's Disease

CASE REPORT

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THE RECOGNITION OF *Pneumocystis carinii* pneumonia in association with another infectious process is vital for the successful treatment of the patient. Although cases of Pneumocystosis have been seen in association with cytomegalic inclusion disease, cryptococcosis, and progressive vaccinia,[1–5] there have been no reports of Pneumocystosis in association with disseminated histoplasmosis.

The occurrence of Pneumocystis infections in children is not uncommon,[6–8] and it also is seen occasionally in adults. When it occurs, there is generally an underlying disturbance of the immune mechanism such as is seen in leukemia, multiple myeloma, and hypoproteinemia.[9–13] The demonstration that pentamidine isethionate is successful in eradicating *Pneumocystis* and providing a longer life expectancy for these patients,[14] makes it necessary to consider this entity in the presence of other underlying diseases.

This report illustrates the clinical features and autopsy findings in a case of Hodgkin's disease complicated by both disseminated histoplasmosis and *Pneumocystis carinii* infections.

Case Report

A 43-year-old Caucasian man was admitted to the University of Wisconsin Hospitals with complaints of cough, fever, and shortness of breath. The patient had a history of Hodgkin's disease of six years' duration. He had numerous previous admissions for radiation therapy, and was maintained on a cyclophosphamide, vincristine, prednisone, procarbazine hydrochloride program on an outpatient basis. Seven months before death the patient had a splenectomy because of a decreasing white blood cell count and thrombocytopenia.

One month prior to admission he developed increasing dyspnea and a nonproductive cough. Cultures were positive for *Histoplasma capsulatum* and the patient was placed on amphotericin B.

On admission the patient was in severe respiratory distress so that he could not rise from the recumbent position. Blood cultures were taken and amphotericin B was reinstituted. The patient's condition rapidly deteriorated, and he was found dead less than 24 hours after admission.

At autopsy the most notable findings were in the lymph nodes, adrenal glands, and lungs. There were numerous large lymph nodes found in the anterior mediastinum and along the course of the aorta. On cut section they were grey–white and homogeneous in consistency. The adrenals had a similar appearance being replaced by lymphomatous infiltrates. The lungs were consolidated and had a combined weight of over 2300 gm. On cut section they were grey–pink and homogeneous.

Microscopically the lungs demonstrated two different processes. There were numerous granulomatous lesions with central caseation necrosis (Fig 1). Similar granulomas were seen in the lymph nodes and adrenal glands. Acid fast stains of these sections were negative, while Gomori's methenamine silver nitrate method (GMS) demonstrated Histoplasma organisms. The pulmonary alveoli contained an intra-alveolar coagulum of finely granular proteinaceous eosinophilic material (Fig 2), this striking feature alone being pathognomonic of *Pneumocystis carinii* pneumonia.[9, 15] GMS stains of these areas revealed the characteristic round-to-oval cysts containing small intracystic bodies (Fig 3). No necrosis, fibrosis or suppuration was seen. Sections of the bone marrow were hypocellular, and no residuum of Hodgkin's disease was found. Sections from the previous splenectomy and lymph node biopsies contained the characteristic histiocytes and Reed–Sternberg cells of Hodgkin's disease (Fig 4). Pulmonary tissue was prepared for electron microscopy by secondary fixation in osmium tetroxide. The sections showed many round forms which contained granular material and a number of irregular clear vacuoles characteristic of Pneumocystis (Fig 5).

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Doctor Nathan is in a four-year residency program in Pathology, under the direction of Henry Pitot, MD, PhD.
Doctor Gilbert, a native of Australia, is Professor of Pathology.
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Figure 1—Granulomatous lesion with central caseation, lung (hematoxylin and eosin, X140).

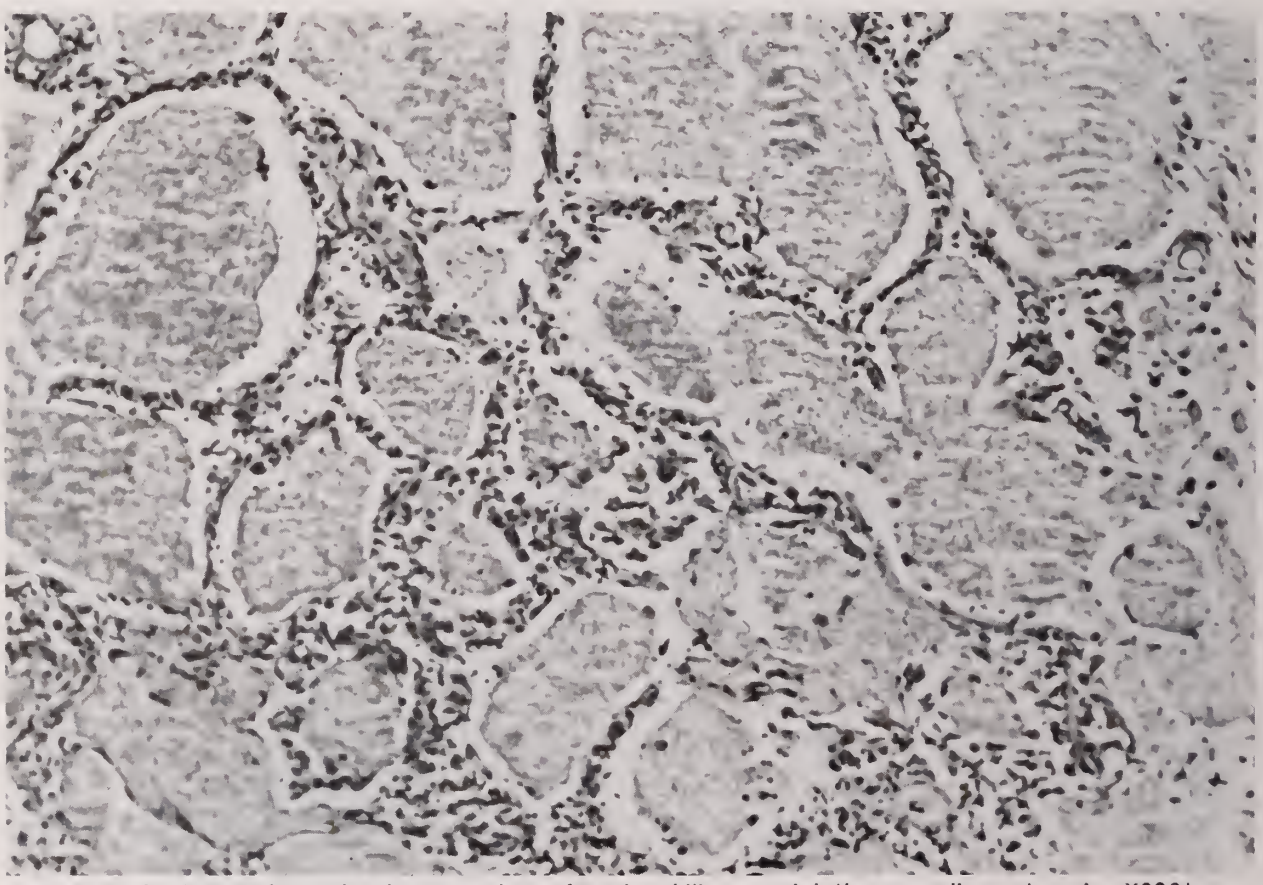

Figure 2—Foamy intra-alveolar coagulum of eosinophilic material (hematoxylin and eosin, X230).

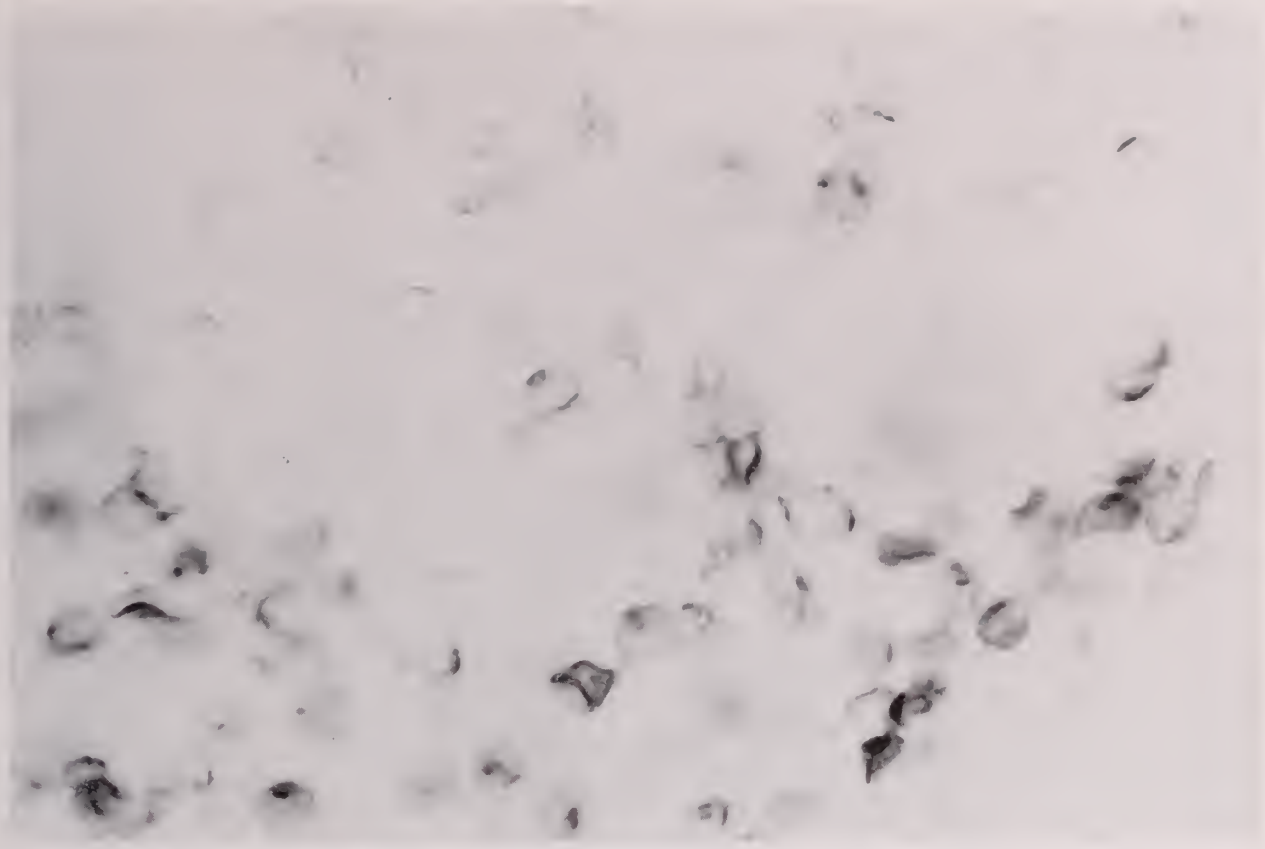

Figure 3—Alveolar material containing cysts with darkly staining intracystic bodies (Gomori's methenamine silver nitrate, X970).

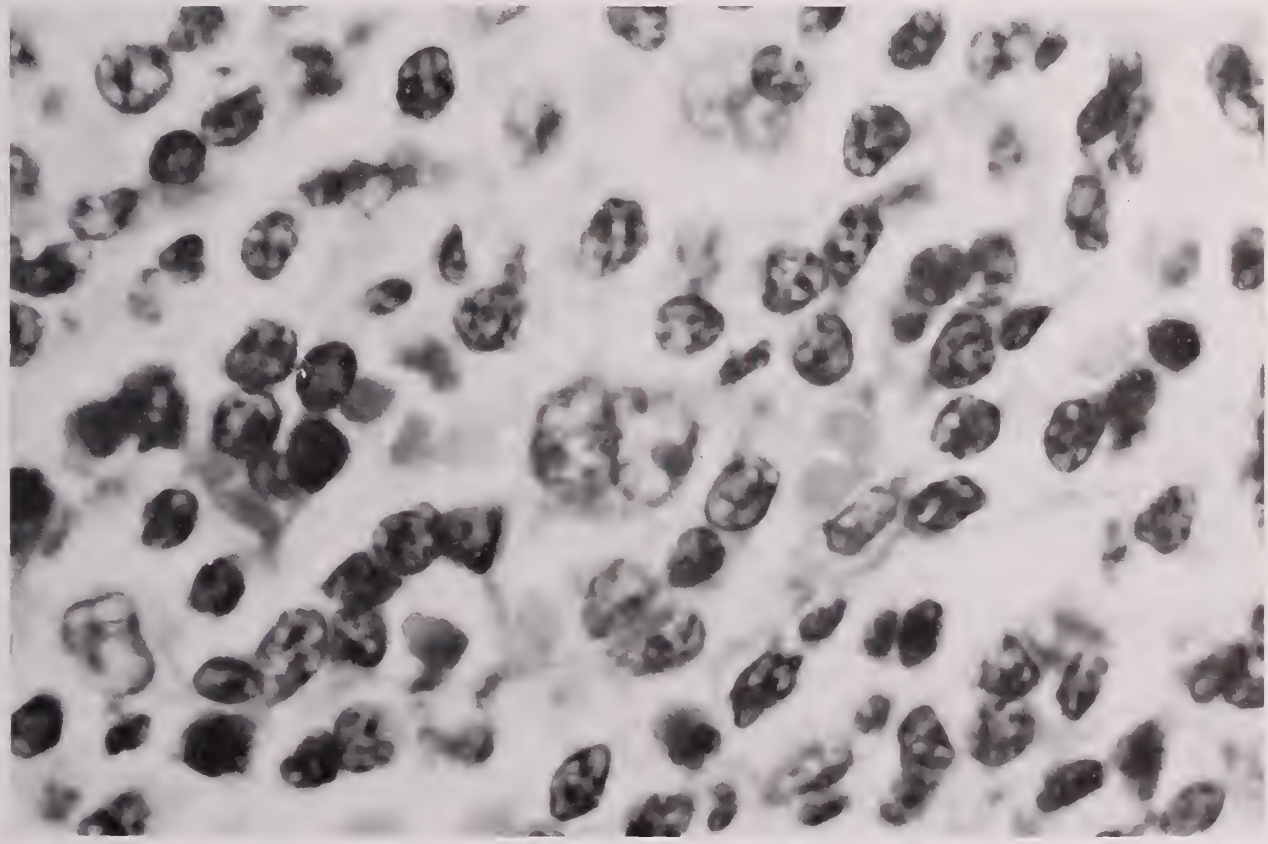

Figure 4—Reed–Sternberg cell surrounded by lymphocytes and histiocytes, spleen (hematoxylin and eosin, X970).

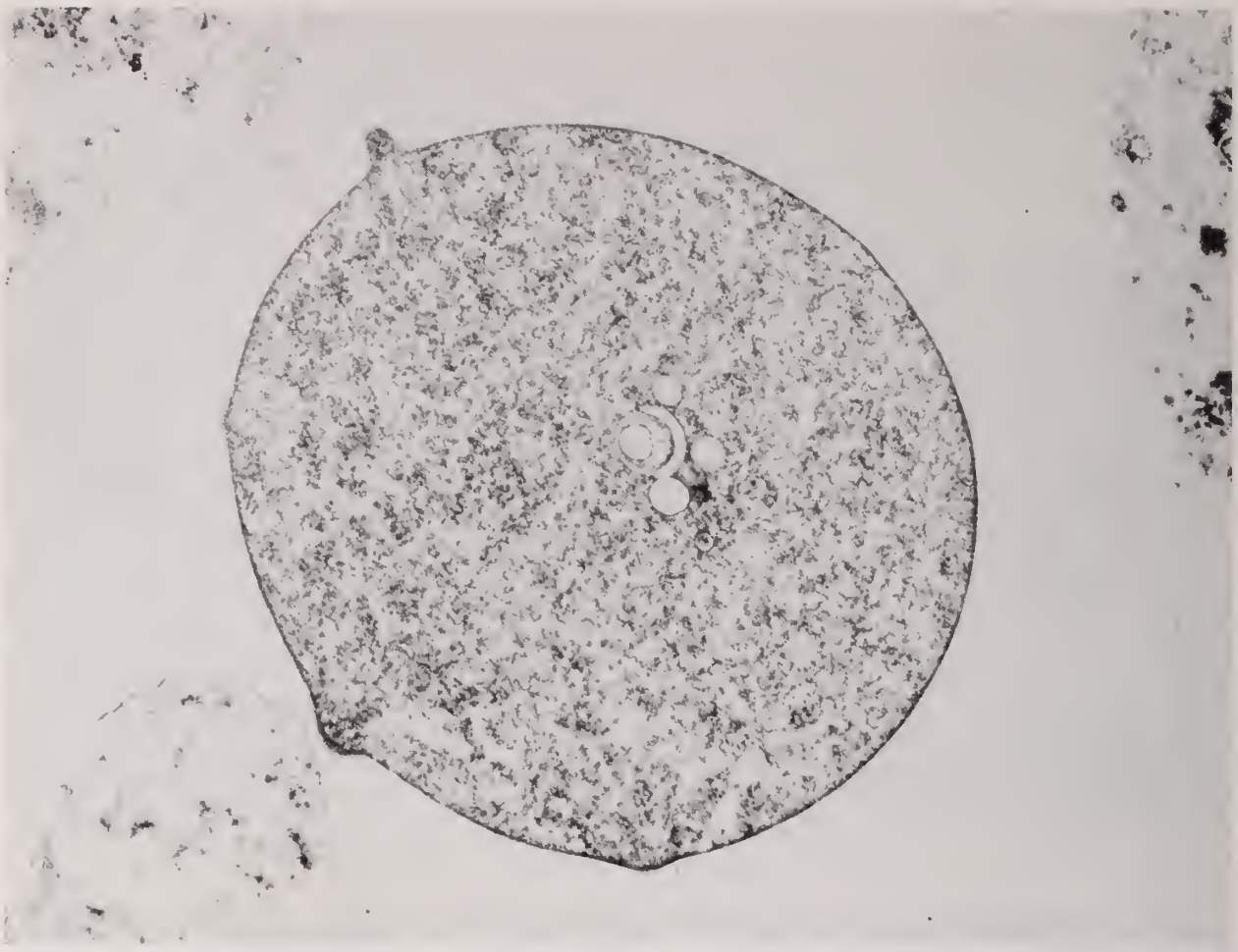

Figure 5—Electronmicroscopic appearance of a round form of pneumocystis with some peripheral projections resembling pseudopodia (X18,400).

Comment

The occurrence of *Pneumocystis* pneumonia tends to vary both with the geographic location and age of the patient. It is reported to be endemic in children in Iran.[16] It is seldom seen in adults in Iran or in the United States.[17] Isolated cases generally follow neoplastic lymphoreticular diseases, steroid therapy, radiation therapy, or the use of cytotoxic drugs.[18–20] In all of these instances a depressed immunologic response is observed. In the case reported the patient was already debilitated from Hodgkin's disease. In addition he had received over 3,000 rads and considerable therapy with cytotoxic drugs. Finally, with splenectomy, the patient was rendered severely immunologically deficient. Post mortem bone marrow examination revealed a hypoplastic marrow with little residuum of Hodgkin's disease. In the case of mixed infections, *Pneumocystis* has been seen in combination with other agents, cytomegalic inclusion virus being the most frequent,[5, 15, 20] In the reported case, the previous identification of pulmonary histoplasmosis masked the second underlying infection.

Lillehei,[14] has demonstrated the value of identification and treatment of pneumocystosis in a leukemic patient. The findings in this case further illustrate the necessity for considering *Pneumocystis* pneumonia in a hypoimmune individual unresponsive to conventional therapy.

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Clinical Evaluation of Highly Water-Soluble Steroids in Treatment of Cerebral Edema of Traumatic Origin (A Double-Blind Study)

HARVEY J HOYT, MD,* Squibb Institute for Medical Research, New Brunswick, NJ, FRANK P GOLDSTEIN, MD, DONALD H REIGEL, MD, and ROBERT HOLST, MD, Department of Neurosurgery, Medical College of Wisconsin, Milwaukee, Wis: *Clin Pharmacol Ther* 13:141 (Jan–Feb) 1972

The efficacy of highly water-soluble steroids in the treatment of cerebral edema secondary to trauma had not previously been evaluated in a double-blind study. Sixteen patients with cranial trauma were evaluated. Patients were placed on equivalent doses of one of three medications, dexamethasone 21-sodium phosphate, triamcinolone acetonide 21-dipotassium phosphate (SQ15, 935, Squibb Institute for Medical Research), or placebo. Medication was assigned sequentially in random order. Patients were treated from date of admission for 14 days. Efficacy was determined by noting the degree of swelling of the brain at surgery, and the level of consciousness and neurologic deficit throughout the study. Five of 12 patients who received steroids demonstrated a marked response to medication. All patients (4) who received placebo demonstrated a marked improvement. Based on this limited clinical double-blind study, the use of steroids cannot be correlated with clinical improvement in the treatment of cerebral edema of traumatic origin. □

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Long-Term Follow-up Study of Patients with Bronchial Anastomosis or Tracheal Replacement

WILSON WEISEL, MD, RAYMOND R WATSON, MD and THOMAS M O'CONNOR, MD, Milwaukee, Wis: *Chest* 61:141–144 (Feb) 1972

There were 21 patients studied with bronchial anastomoses or tracheal resective graft procedures who were studied 7 to 17 years following their reconstructive operations. Three of the patients had disruptive traumatic lesions of the major bronchi. There were five patients who had tracheal resection because of tracheal adenomas, four of these being carcinoids and one a cylindroma. There were 13 patients who presented bronchial adenomas of the carcinoid variety that were treated by bronchial and/or pulmonary resection with subsequent bronchial anastomoses and reconstruction.

In this study, no patients have succumbed to obstructive airway complications and there has been no evidence of recurrence of tumor. The bronchial reattachment have shown an excellent restoration of distal lung function. These have been carefully measured by thorough pulmonary function examination of all physiologic parameters. In the tracheal resection grafts of the patients, pericardium were utilized to reconstruct airway and these have been effective in maintaining the respiratory airway stability and distal pulmonary function.

The immediate study of these patients following bronchial anastomoses and tracheal replacement, the uptake of oxygen has been often diminished following this procedure, although it has returned to normal within a period of time on follow-up examinations.

One of the interesting sidelines that has been brought out by this particular long-term study of patients has been the fact that in repeated biopsy studies of the anastomoses and tracheal grafts, it has been demonstrated that after a period of three to five years regeneration of ciliated epithelium may be demonstrated in these patients. □

Granulomatous Ileocolitis with Multiple Fistulae Treated with Gut Rest, Hyperalimentation, and Antibiotics

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CASE REPORT

DUDRICK *et al*[1] FIRST SHOWED that positive nitrogen balance with normal growth and development can be achieved by giving basic ingredients solely by the intravenous route. They raised a group of beagle puppies to complete maturity with only intravenous feedings and also maintained a group of patients solely by the intravenous route for periods of up to 200 days.[1–3]

The following case is reported to show how a modified Dudrick hyperalimentation plan was used, with gut rest and antibiotics, as an alternative to extensive bowel surgery in a patient with severe granulomatous colitis, multiple fistulae, and severe malnutrition. The hyperalimentation modifications used were based on several year's experience in the use of hyperalimentation by one of the authors (B.A.W.) while patients with overwhelming infections, severe burns, ulcerative colitis, ruptured appendices, and postoperative complications of surgical repair of the esophagus were being treated with this modality. It is felt this presentation might find application in other patients who are unfit for surgery and who need gut rest.

Case Report

A 21-year-old Caucasian woman was admitted to the hospital on Oct. 3, 1970, complaining of weakness, anorexia, diarrhea, fever, and weight loss. Her history revealed that in 1964 she was operated upon for granulomatous ileocolitis. At that time 40 cm of her terminal ileum and the proximal half of her ascending colon were resected without ascending ileocolostomy. She did well until February 1970, at which time diarrhea, fever, anorexia, and weight loss began again. Anal and rectovaginal fistulae were diagnosed. For six months thereafter there was moderate improvement on corticosteroids and supportive therapy. This included weight gain, decrease in stools, and improved strength. She then relapsed and was hospitalized. In the hospital she had a relentless downhill course, and after two months her weight had dropped to 70 lb. Three abdominal fistulae, a rectal fistula, and a rectal–vaginal fistula were demonstrated. She had persistent abdominal tenderness, fever, tachycardia, and anemia. Proctosigmoidoscopy and barium enema roentgenograms revealed complete colon involvement. Progress meal x-ray films revealed several feet of ileum contiguous with the anastomosis to be involved. The ileo–cutaneous fistula arose from this portion of the ileum. Surgery, which would have required total colectomy with removal of several feet of ileum and creation of an ileostomy, was ruled out at that time because of the patient's tenuous condition. As an alternative to surgery, a program for gut rest, gut sterilization, parenteral hyperalimentation, antibiotics, and supportive measures was decided upon.

Therapeutic Regimen That Was Used For 61 Days

1. NOTHING BY MOUTH

   The patient was allowed nothing by mouth in order to keep the bowel at rest, both mechanically and in regard to secretion and to reduce the passage of chyme through the fistulous passage.

2. ANTIBIOTICS

   Chloramphenicol, 8 gm; crystalline penicillin G, 10 million units; and gentamicin, 60 mg, were given intravenously daily to control and prevent any systemic infection. Gamma globulin was added to potentiate the action of antibiotics.[4, 5] In addition neomycin, 2 gm, and vancomycin, 2 gm, were given orally each day to reduce the total bowel flora.[6]

3. HYPERALIMENTATION SOLUTION

   A liter of hyperalimentation solution* contains 250 gm of dextrose, 50 gm of modified protein hydrolysate, and electrolytes. It supplies 850 nonprotein calories with each gram of nitrogen to supply energy for protein synthesis and metabolic needs of the body. We modified this solution by adding to each liter:

Alcohol 95%	35 ml
Insulin	25 IU
Neomycin	1 mg
Amphotericin B	1 mg
Polymyxin B	5 mg

Alcohol was added to increase the caloric content. Insulin was added to accelerate the utili-

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Prize winning paper presented at Mount Sinai Medical Center Clinic Day, Mar. 18, 1971.

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* Available from McGaw Laboratories

TABLE 1—*Illustrative Hyperalimentation Flowsheet*

Suggested flowsheet for use with hyperalimentation. This is kept up-to-date daily, but for the sake of illustration the authors have placed the values as determined on the first day of each week on the patient they have described.

DAY	1	8	15	22	29	36	43	50	57
WEIGHT	80	90	104	109	111	116	118	120	125
CALORIC INTAKE	2610	3770	4230	4100	4200	3800	3900	4100	5700
GM.- CARBOHYDRATE	522	754	846	820	840	760	780	820	1140
GM.- PROTEIN	93	135	151	146	150	136	139	146	203
SERUM K	4.3	4.8	4.9	4.0	3.9	4.8	4.6	4.6	4.0
K INTAKE	150	230	225	210	210	210	210	210	210
K OUTPUT	127	132	140	120	150	132	144	190	180
SERUM NA	135	138	138	139	139	139	138	139	138
NA INTAKE / NA OUTPUT	THESE WERE NOT DETERMINED ON THIS PATIENT BUT ARE SUGGESTED								
BUN	7	8	8	9	10	10	9	7	12
SERUM OSMOLALITY	261	280	280	278	276	277	275	274	297
F.B.S.	45	50	60	90	80	85	71	80	80
SERUM ALBUMIN	3.0	2.7	2.8	3.0	3.0	2.9	3.2	3.4	3.9
HEMOGLOBIN	10.0	10.8	10.6	11.1	10.8	10.7	10.2	10.6	11.2
WBC in Thousands	13.5	10.5	10.6	8.0	5.3	4.2	4.3	4.8	7.2

HINTS to help in filling out hyperalimentation flowsheet accurately:

CALORIES: Protein -- 4/gram; Carbohydrate -- 4/gram; Fat -- 8/gram; D/5/W -- 200/liter; McGaw's solution unmodified -- 850/liter; Ethyl alcohol -- 7/ml.

POTASSIUM: McGaw's solution -- 18 mEq/liter; Ringers (Hartmann's) -- 4 mEq/liter; Penicillin G (potassium buffered) -- 1.7 mEq/million units

STOOL: Daily normal stools have only 2.6 mEq. of K and 7.6 mEq. of Na so, unless they are extensive, loss by this route can be ignored on this sheet.

NA: Keflin 2.26 mEq/gram; Carbenicillin 5.7 mEq/gram; Ringers 147.5 mEq/liter; Saline 154.0 mEq/liter

zation of carbohydrates. Minimal amounts of antibiotics were used to prevent any bacterial or fungal contamination in the bottle.[7, 8] These antibiotics kept the hyperalimentation solutions sterile for long periods of time so that they could be given without filters or pumps. Vitamin intake was maintained by giving, daily, 10 ml of intravenous vitamin solution (Solu B & C®). Folic acid, vitamin B_{12}, intramuscular iron, potassium, and blood transfusions were given as necessary.

Hydrocortisone and 6-mercaptopurine, begun before the new regimen, were continued during part of this program, being decreased and then discontinued after 54 days.

The patient was monitored in regard to weight, total fluid intake and output, hemoglobin, hematocrit, reticulocyte count, total red cell, white cell, and platelet count, urine and blood sugar, serum and urine osmolality, and urine and fistula drainage cultures and sensitivities (Table 1).

This regimen was continued for 61 days.

Results

The program outlined seemed beneficial from the beginning. The patient became afebrile and shortly began to gain weight. Fistula drainage decreased in one week and almost ceased at the end of three weeks. The patient gained 45 pounds during the next nine weeks. There was no evidence of hemopoietic depression from the antibiotics. Oral alimentation was started gradually on the 55th day and the patient was discharged on a high protein, low residue diet with supplementary vitamins.

During the five month follow-up period she maintained her weight and had three or four stools daily. Fistula drainage had been negligible except for one outpouring of greenish brown fluid. Therapy with 6-mercaptopurine was started in doses of 25 mg per day three and a half months later because she developed diarrhea and her sedimentation rate was still elevated.

Discussion

Several points of emphasis seem to be worthy of mention. In our patient the same subclavian catheter, which had been placed by subclavian stick, was kept in place with no evidence of intolerance during the entire nine weeks. This is entirely consistent with our overall experience in hyperalimentation. Numerous cultures of the fluid, after it had been infusing for 24 hours, were negative. This showed that the small amounts of antibiotics put in the solution itself kept it free of both bacterial and fungal growth.[7, 8] The placing of these antibiotics in the solution allows one to do away with the potential danger of a pump, which is often used with hyperalimentation, since the hyperalimentation solution can be given with a usual intravenous set.[7, 8] Flowsheet monitoring of the patient was quickly mastered by our ward personnel; and hyperosmolality and hyperglycemia, two fearsome complications of hyperalimentation, did not occur[9] (Table 1).

There are, of course, methods other than hyperalimentation for putting the bowel at rest than were used here. Truelove *et al*[10] found double-barreled ileostomy (with or without corticosteroids) followed by limited surgery, valuable in patients with Crohn's disease affecting part of the colon. Oberhelman and his associates[11] had excellent response to proximal diverting ileostomy in all 13 patients with Crohn's disease of the colon, with or without ileal involvement. However, there are many reasons why patients with inflammatory bowel disease and fistulae make poor surgical candidates. The relative safety of hyperalimentation combined with maximum tolerated doses of antibiotics might make a trial of a program such as we have outlined justifiable in patients of this type who need temporary gut rest. This could be used as an adjunct of surgery if it became necessary but in some cases, such as the one outlined here, it might make surgery unnecessary. The safety of the antibiotics, particularly the chloramphenicol, has been commented upon in the past by one of the authors so it will not be belabored in this report.[12, 13]

Summary

A young girl with recurrent granulomatous ileocolitis and multiple fistulae was treated with a medical program of gut rest for 61 days, during which time her nutritional needs were adequately supplied by the intravenous route and secondary infection was controlled by maximum dosages of antibiotics. It was thought worthwhile to share this experience because the excellent result obtained suggested that this regimen might be a reasonable alternative to surgery in some patients with this disease.

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Gonorrhea in Adolescent Girls in a Closed Population Prevalence, Diagnosis, and Treatment

HANIA W RIS, MD and RUTH W DODGE, MS, Madison, Wis: *Amer J Dis Child* 123:185–189 (Mar) 1972

In a closed population of adolescent girls, vaginal and cervical smears and cultures were evaluated for diagnosis of gonorrheal infection. In a population of 1889 girls, 226 (11.8%) gonorrheal infections were diagnosed on primary admission or readmission. Of 268 specimens, 177 (66.2%) were positive by the culture method and negative by the gram stained smear (Table 2). Using vaginal specimens, 213 (94.2%) positive diagnoses were made. Cervical specimens, taken at a later time, revealed an additional 13 (5.8%) positive cases. One case of gonorrheal pelvic inflammatory disease and one case of gonorrheal mono-articular arthritis were diagnosed.

Table 2.— Positive *Neisseria gonorrhoeae*: Comparison of Gram Stain vs Culture

Diagnostic Method*	Number	% Positive
Gram-stained smear positive; TM† culture negative	16	5.9
Gram-stained smear positive; TM culture positive	75	27.9
Gram-stained smear negative; TM culture positive	177	66.2
Total specimens positive	268	100.0

* The site of origin of specimens was the vagina in 93% and cervix in 7%.
† Thayer-Martin medium.

From 1966 to 1968, 121 patients treated with 5 daily injections of aqueous procaine penicillin G, 1.2 million units, showed 3 (2.3%) treatment failures. From 1968 to 1969, 62 patients treated with 2.7 million units in a combination of buffered crystalline and procaine penicillin G in aqueous solution showed 4 (6.4%) treatment failures. These two treatment regimens, instituted at different times, do not lend themselves to comparison as to the effectiveness of treatment.

This study has demonstrated that vaginal specimens in adolescents are a good substitute for cervical specimens when the facilities for cervical study in pediatric practice are unavailable. The pediatrician is often reluctant to conduct a pelvic examination and the adolescent is unwilling to have the speculum introduced. Under these circumstances, the vaginal culture is an excellent compromise from the standpoint of physician and patient considering the high yield of positive cultures from the vagina. Only 0.7% of all patients were positive by cervical cultures after previous vaginal cultures were negative. As we did not obtain paired cervical and vaginal specimens, and ours were repeat cultural examinations, one may speculate that there would have been less of a differential had we taken them.

It is well established that gram stained cervical or vaginal smears are unreliable for diagnosis of gonorrhea in the female for the following reasons: Large numbers of bacteria in vaginal exudates make reading of smears difficult and confusing, and the proportion of *Neisseria* to the total number of bacteria may be so small that they are overlooked. Certain other bacteria, *Escherichia coli, Mima,* and other *Neisseria* species have similar morphology and may be confused with *N. gonorrhoeae*. Smears from the urethra in males are more satisfactory for diagnosis of gonococcal infection, because this infection tends to become more localized and there is a paucity of confusing bacterial flora.

The leukorrhea of acute gonococcal infection is described in textbooks as a profuse, purulent, yellowish-green discharge emerging from the cervix. Only in rare instances was this clinical picture seen. Many times the leukorrhea was so minimal that infection was not even suspected, and often the patients were completely asymptomatic.

There are only a few reports of gonorrheal arthritis in children and adolescents since the advent of antibiotics, yet arthritis is the commonest extragenital complication of gonococcal infection. In children and adolescents, gonorrheal arthritis should be considered along with rheumatic fever and rheumatoid arthritis in differential diagnosis of multiple —as well as single—inflammatory joint disease.

It is apparent that gonorrhea has reached epidemic proportions in the teenager. It is of utmost importance that the pediatrician should familiarize himself with the particular problems of the current epidemic and determine the extent of the gonorrhea problem in his practice by more routine utilization of vaginal cultures, even in the absence of leukorrhea. Presence of the menstrual period is no contraindication for obtaining a specimen; on the contrary, it is more likely to yield a positive culture, since the pH of the cervix at that time is optimal for the growth of *N. gonorrhoeae*.

Strategy for control of gonorrhea requires more than physicians' participation; health education is also essential. The recent White House Conference on Youth, in April 1971, passed a resolution on venereal disease control, endorsing an educational program in the junior and senior high school curriculum. This should be an objective and factual program, with consideration of prevention, transmission, and treatment of venereal diseases. Another ingredient in the control program requires the proper legal frame work. Often, the adolescent is reluctant to inform his parents of suspected venereal disease and therefore does not get treatment. So far, 34 states and the District of Columbia now have laws which permit treatment of minors without parental consent or knowledge. In six other states, the opinion of the attorneys general allows treatment of minors for venereal disease. □

Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

A Practical Approach to Upper GI Bleeding

DAVID SULMAN, MD
Madison, Wisconsin

UPPER GASTROINTESTINAL BLEEDING remains a difficult problem in the community hospital and referral center alike. Diagnostic maneuvers have improved, medical and surgical treatments have changed, but the mortality rate has remained fairly constant over the past 15 years. This may relate to the fact that most bleeding stops even without treatment, and deaths are due more to associated medical conditions than to blood loss. A brief discussion of one practical approach to the problem may be helpful.

A few important questions on first seeing the patient may suggest common causes of bleeding. Are there recent ulcer symptoms (periodic pain or indigestion relieved by food or antacids, especially at night)? A previous diagnosis of duodenal ulcer is less helpful, since the current bleeding commonly comes from another area. Hematemesis suggests bleeding anywhere from the duodenal bulb proximally. Melena can originate anywhere from the nose distally. Retching ("dry heaves") followed in several minutes by bright red hematemesis suggests a traumatic tear at the cardia (Mallory–Weiss syndrome). Recent heavy alcoholic intake or large doses of salicylates, indomethacin, phenylbutazone, or other gastric irritants suggest bleeding from erosive gastritis or gastric ulcer.

Has blood loss been massive? It takes only 50 ml of blood to produce a tarry stool, and even less to color the toilet red. Frequent loose black stools or maroon colored stools suggest recent heavy bleeding.

What about associated conditions? Heart disease dictates caution, lest the circulation be overloaded by transfusions. Previously documented high blood pressure may mean the current "normal" blood pressure is at shock levels for this patient.

The initial brief physical examination focuses mainly on evidence of hypovolemia. Remember to check for postural hypotension. A normal pulse and blood pressure while reclining may change dramatically when the patient stands, implying early shock. Signs of chronic liver disease such as spider angiomas and enlarged liver or spleen or ascites, may suggest the patient has esophageal varices.

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A more complete history and physical examination should await the following two urgent procedures:

(1) Drop down a nasogastric tube, especially if there has been *no* hematemesis. Lesions of the esophagus and stomach are notorious for causing only melena. Fresh or old blood aspirated from the stomach points to a lesion above the descending duodenum, and may be the only localizing sign if subsequent x-ray studies are negative. If there is no blood, leave the tube down for a few hours on suction, to check for a lesion that might have temporarily stopped bleeding but may resume. If there is active bleeding, its rate can be monitored by nasogastric suction.

(2) A large bore [number 18 or larger] needle in a vein will provide blood specimens for a few emergency tests [complete blood count, prothrombin time, type and cross match, serum creatinine, and the like], and will keep a vein open for blood transfusions.

What about endoscopy, upper gastrointestinal x-ray, and more sophisticated radiological techniques?

There are advantages to doing endoscopy the day of admission. In one large series, almost one-fourth of patients endoscoped as an emergency were bleeding from esophagitis, gastritis, or Mallory–Weiss syndrome, lesions that do not show on upper GI x-ray and may be healed if endoscopy is delayed. In addition, endoscopists often find more than one *potential* source of bleeding, such as esophageal varices plus duodenal ulcer, gastric ulcer, or hemorrhagic gastritis. Seeing which lesion is *actively* bleeding greatly influences treatment. Emergency endoscopy has shown that cirrhotics are likely to be bleeding from sites other than their varices. Performing emergency portacaval shunt for a patient bleeding from gastritis or duodenal ulcer, or conversely, ulcer surgery for bleeding from esophageal varices, can be disastrous.

On the other hand, active bleeding during endoscopy may make visualization difficult, precluding an accurate diagnosis. Emergency endoscopy also may be hazardous for the patient. A recent prospective randomized study from Chicago found that patients having endoscopy as an emergency procedure had a higher incidence of continuous and recurrent bleeding than those for whom endoscopy was delayed one week.

The radiologist who performs emergency upper GI x-ray studies may encounter similar problems. Bleeding patients may be uncooperative, yielding films that are blurred and difficult to interpret. In many cases, blood in the GI tract, or the patient just having eaten, may obscure parts of the stomach and duodenum, resulting in inadequate films.

A reasonable compromise is to treat the patient conservatively with transfusions, ice water lavage, and nasogastric suction. When his condition stabilizes, if history suggests active peptic ulcer, upper GI x-ray series can be obtained first. If this is negative, endoscopy can be done a few days later. If there is evidence of chronic liver disease or recent ingestion of alcohol or salicylates, endoscopy should be done first to look for bleeding esophageal varices or gastritis.

If bleeding does not stop and surgery is imminent, endoscopy should be done immediately to identify the bleeding site.

What about angiograms? When done by experts, injection of contrast material into branches of the abdominal aorta and their tributaries can pinpoint active bleeding at a rate as little as 0.5 ml per minute. At the same time, bleeding can be stopped by injecting vasoconstrictors (vasopressin [Pitressin®] or epinephrine) into the bleeding vessel. This is especially effective for stopping bleeding from esophageal varices. In some patients with varices, a constant drip of Pitressin® into the superior mesenteric artery has been continued for several days until the time of portacaval shunt surgery. In others, bleeding has remained stopped after discontinuing the Pitressin,® obviating the need for shunt surgery. This treatment has its own complications, different from, but perhaps as serious as those of esophageal balloon tamponade.

Angiography is difficult to perform and to interpret. It probably should be restricted to those patients for whom history and endoscopy are not helpful, especially those with previous undiagnosed GI bleeding. It requires that the patient be actively bleeding during the injection of the dye, and must be done before barium studies.

What if there is no endoscopy or angiography available in your community? In most large series at least 70% of upper GI bleeding comes from peptic ulcer disease. In private hospitals this may approach 90%, since alcoholism and its resultant gastritis and varices are less common than in city or county hospitals. Thus, treating the patient as if he had an ulcer (nasogastric suction until clear, followed by hourly antacids) will usually be effective. Bleeding usually stops after one to three days of this treatment.

The most troubling bleeders are those with esophageal varices, and recurrent GI bleeding following ulcer surgery. These problems, and bleeding from other unusual sites, may best be referred to centers where endoscopy and angiography are available.

When, and what type of surgery is best for massive upper GI bleeding?

As a diagnostic tool, surgery leaves much to be desired. Bleeding often stops once the patient is anesthetized, and the surgeon is faced with a stomach or bowel full of blood and no obvious lesion. Even a gastric ulcer may be missed if its white mucous base is wiped away when the surgeon clears the stomach. Partial gastrectomy may either be unnecessary (if bleeding has stopped) or the wrong

operation (if bleeding comes from an esophageal lesion or gastritis). This shows the need for an accurate diagnosis before surgery.

The timing of surgery and choice of operation must be individualized, and are controversial issues. Recent studies suggest that for bleeding duodenal ulcer. vagotomy, pyloroplasty, and oversewing the bleeding vessel may be more effective than partial gastrectomy, has a lower operative mortality, and less recurrent bleeding. For gastric ulcer, subtotal gastrectomy is still the procedure of choice.

Surgery for bleeding gastritis is frequently disappointing and mortality is high. Vagotomy and pyloroplasty may be the procedure of choice for this condition since it leads to a decrease in both gastric blood flow and acid secretion. □

RESEARCH NOTES

Blood Clot-dissolving Drugs Under Study at Marshfield

Drugs that may reduce permanent cardiac damage in heart attack sufferers are being studied by the Marshfield Clinic Foundation at St. Joseph's Hospital in Marshfield, Wisconsin.

The research, known as the Streptokinase–Urokinase Myocardial Infarction Trial (SUMIT), is sponsored by the National Heart and Lung Institute, Washington, D.C. The program began in January, with first year funding totaling $57,800.

Richard Sautter, MD, Marshfield Clinic heart surgeon and principal investigator for the study, said the research involves the drugs, streptokinase and urokinase.

It is believed that the two drugs being studied in Marshfield will dissolve the heart attack-producing blood clots. By lessening the time the muscle is without blood, the amount of permanent damage should be minimized. The patient would then be in a better physical condition to receive conventional treatment aimed at preventing another attack.

Area physicians, the Marshfield Clinic cardiologists, and the personnel of the cardiac care unit at St. Joseph's Hospital all play vital roles in the study, Doctor Sautter noted.

The doctor attending a heart attack patient is asked to report such a condition to the Marshfield research team. If, after receiving an explanation of the project, the patient wishes to participate, special lab tests and electrocardiograms (EKGs) are performed. After careful examination of this data by a cardiologist, treatment begins.

The tests must be completed within 24 hours of the heart attack, the research team stated. Otherwise, the clot may be too firmly formed for the drugs to be effective. All vital signs are monitored and blood tests are taken periodically for the duration of the study, usually 21 days.

According to Frederick Wenzel, executive director of the Marshfield Clinic Foundation, the effectiveness of the two clot-dissolving drugs in treating heart patients can be measured by survival statistics in a large group of patients. A preliminary report by a European research group showed almost a 40% decrease in the mortality rate of those receiving streptokinase or urokinase.

The Marshfield Clinic Foundation–St. Joseph's Hospital project will study 300 patients over a three-year period. Similar research is being conducted at seven other U. S. hospitals, including Boston City Hospital and the George Washington University Medical Center in Washington, D. C. □

Clinical Center Study of Patients with Ovarian Carcinoma

The cooperation of physicians is requested in the referral of patients for a controlled clinical trial of the treatment of advanced ovarian carcinoma being conducted by the National Cancer Institute's Solid Tumor Service at the Clinical Center, National Institutes of Health, Bethesda, Md.

Previously untreated patients with serous or undifferentiated ovarian carcinomas Stage III or IV (International Classification) are needed for this study.

Of particular interest are patients with ascites, since pretreatment assessment of aspects of the cell cycle estimations of the effectiveness of each dose of administered drug and other studies are performed on available tumor tissue prior to therapy.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings. Physicians interested in having their patients considered for admission to these studies may telephone: Vincent T. DeVita, MD *or* Robert C. Young, MD, 301/496–2031, or write: Admitting Office, National Cancer Institute, Clinical Center, Room 4-B-17, Bethesda, Md. 20014. □

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Parents of Severely Ill Newborn Infants

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THE BIRTH PROCESS IN HUMANS is followed by several characteristic emotional changes in parents, and these changes partially depend upon the attitudes and factors surrounding the pregnancy and delivery of the baby. Bibring[1] defines pregnancy as a maturational crisis which must be mastered so the woman accepts her role as a mother. The expectant mother initially must accept the growing fetus as a part of herself. With quickening she must realize that the growing fetus is, in addition to a part of herself, a new life of its own. Following delivery, the mother must then accept her infant as a new individual completely separate from herself.

Pregnant mothers have definite ideas of the baby they expect to deliver. These include wishing for a perfect child and the fear of having a damaged child.[2] For most mothers there is a certain difference between the anticipated character of the infant and the mother's expectations, and it takes time for her to adjust. Although a newborn infant may be completely normal in every respect, frequently some parents will be fearful for the health of their baby.

When the newborn infant is premature, ill at birth, or becomes ill while in the nursery, there are additional crises for the parents. Caplan's group[3, 4] suggests that prematurity constitutes a unique psychological crisis for the mother. The premature infant presents with an unexpected onset of labor, and the atmosphere of the hospital around the premature delivery is one of increased solicitude by the staff. The mother is deprived of the anticipated last weeks of pregnancy which she might have used for further adjustment of her feelings about the impending labor and delivery, as well as for more complete preparation of herself for relating to her new baby.[5]

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Although Caplan's concept of mothers' attitudes about prematurity[3, 4] is supported by some,[5, 6] it is not universally accepted. A recent study of the mood and attitude of mothers of premature and full-sized infants suggests there is little difference between a mother's attitude on accepting pregnancy, accepting motherhood, or concerning herself with the baby's welfare.[7] This study defined prematurity as a birth weight of 1,401 to 2,500 gm and excluded infants with serious newborn diseases. Opposing viewpoints may have arisen from basic differences in the studies, such as the socio–economic status of the sample population.

Infant separation resulting from the transfer of an ill newborn from a community hospital to a regional intensive care unit causes additional anxieties and concerns. Sick infants frequently are now taken several miles from the parents after birth, leading to total separation of infant and family. The maternal problems of separation–deprivation have recently been reviewed,[8] and most studies have dealt mainly with the consequences to the infant rather than the mother.[9–11] Pilot studies have now demonstrated the possibility of admitting mothers to the premature nursery without disrupting the care of the infants or increasing the occurrence of infection.[8] In addition, an objective study of maternal behavior at the first contact with her young has been published.[12] An orderly progression of behavior in mothers of full-term infants started with fingertip touch on the infant's extremities and proceeded in a few minutes to massaging and palm contact. A significant observation was that the mother rotated her face so her eyes and those of her infant could meet in the same vertical plane. Mothers of normal premature infants who were allowed to touch their babies in the first three to five days of life followed a similar pattern, but progressed at a much slower rate. The authors suggested that this might indicate an unhealthy arrest in the progression of maternal behavior.

Another recent study was concerned with the mourning process following the death of a newborn infant.[13] The study included 18 mothers who had lost infants, most of whom were small prematures living one to 264 hours. No primiparae were included. Seven to 20 weeks after the infants' deaths, the mothers were interviewed. Six criteria of mourning were used: sadness, sleeping problems, eating difficulty, irritability, preoccupation with death of the baby, and inability to return to normal daily life. If several or all of the criteria were present, mourning was considered present. The study attempted to distinguish between high and low mourners, based on the duration of the mourning process. Some degree of mourning was present in all the mothers. Mourning was more intense if the pregnancy had been desired, if there had been a previous loss, or if the mother had had tactile contact with the sick infant, and mourning was lengthened if the infant lived for longer periods. The authors felt that longer mourning did not produce a pathologic response in the mothers.

There are fewer well defined concepts, less understanding and seemingly only marginal concern about how a father accepts pregnancy, the newborn infant, or a sick newborn daughter or son. Dr. H. Kent Tenney has underscored this in a recent "March of Medicine" broadcast (No. 522)* entitled "Fathers Are Parents Too." One would expect anxieties and feelings of similar magnitude to those experienced by the mother.

THE PROBLEM

At the Neonatal Intensive Care Unit in Madison, over half of the infants are transferred to the Unit from outlying community hospitals. During the last two and a half years, there have been over 600 patients admitted to this Unit, and more admitted to the Neonatal Intensive Care Units of Milwaukee County General Hospital, Milwaukee; St. Francis Hospital, La Crosse; St. Vincent's Hospital, Green Bay; St. Joseph's Hospital, Marshfield; and Theda Clark Hospital, Neenah–Menasha. During 1970, there were 606 infants admitted to these regional units. Therefore, in the State of Wisconsin there is a rapidly increasing number of parents who must adjust to the concept of neonatal intensive care, accept separation from their sick son or daughter immediately after birth, and travel distances which often preclude early or frequent contact with their infant. The personnel—physician, nurse, and allied health staff—working in the regional neonatal intensive care units, as well as the personnel in the referring hospital, must be aware of the psychological and emotional impact on the parents of these sick babies.

The purposes of this report are to describe ongoing programs designed with consideration for the unfortunate parents of sick newborn infants, to outline some projects that are in the planning stages, and to solicit the readers' interest and suggestions. Programs we have initiated and planned thus far are designed to fulfill Dr. Caplan's suggestions as outlined in a pamphlet distributed by the National Research Bureau.[14] Specifically these goals are to:

(1) Aid the parents in confronting the crisis.
(2) Help parents understand the facts.
(3) Avoid giving false reassurance.
(4) Discourage blaming themselves or others.
(5) Where appropriate, help parents recognize when they need to accept help.

* A continuing radio program of the State Medical Society of Wisconsin.

ONGOING PROJECTS

Visiting and Communications

The Neonatal Intensive Care Unit at Madison has virtually unrestricted limitations for parent visitation. Parents are encouraged to visit regardless of how sick their infant may be. They are invited to come at any time of the day or night, although visiting is not permitted during nurses' signout rounds, doctors' teaching rounds, or when another infant in the Unit is undergoing a procedure such as intubation, lumbar puncture, and the like. Parents are supervised while they wash hands and wrists with pHisohex. They are then helped into a long-sleeved gown and enter the nursery. No masks or hair nets are required. The parents touch only their own infants while in the nursery. (If a parent has an obvious or questionable sign of illness, such as an upper respiratory tract infection, pustules, post-operative drainage tube, and the like, they are asked not to enter the Unit.) Parents are accompanied by either a nurse or a physician to the crib or incubator of their infant. Details of the care of the infant, his present condition, possible diagnoses and prognosis, and equipment being used are discussed in nonmedical language in as much detail as necessary to aid the parents' understanding and to answer their questions.

Parents are encouraged to touch their infant at each visit, including the first. This is true even in the case of the severely ill infant who may require a respirator, intravenous therapy, constant monitoring, and other supportive care. Only rarely have grandparents been allowed in the nursery. These exceptions have been grandparents who were leaving the country or who wanted to see their grandson or granddaughter whose condition was terminal. Siblings of the sick infant are allowed on the nursery floor and may view their infant brother or sister through a window, but they have not been allowed to enter the nursery *per se*.

Visiting parents frequently take pictures of their infant, and this has been encouraged. As a baby begins to recover, the parent is allowed to take a more active part in his care, such as changing a diaper or helping with a feeding. Before a baby is discharged, the nursing staff supervises the parents according to their needs with a bath demonstration, care of circumcision, administration of medications, and the like.

Communications with the parents of infants transferred to Madison from community hospitals is necessarily initially handled by telephone. When the baby is severely ill, our physicians try to call at least once daily, and an attempt is made to contact a parent immediately if the baby's condition worsens. Parents also are encouraged to phone the Unit. Parents may speak to a nurse about their baby or they may request to speak to a physician, since there is physician coverage 24 hours a day in the Unit. As the baby improves, the number of phone calls by the physician decreases accordingly. Each patient's chart has a special sheet on which is entered a note concerning the latest communication. Hence, anyone in the Unit receiving a call from a parent can pull the baby's chart and read exactly the last information given to the parents. The most recent progress then can be conveyed to the parents, and this is noted on the chart.

Parents of infants born at St. Mary's Hospital in Madison have more frequent opportunities for communication and visiting. For example, the mother usually sees both the obstetrician and pediatrician daily while she is in the hospital. Parents from the immediate Madison vicinity have less traveling distance when making visits after the mother is discharged from the hospital. Parents frequently relate to one particular house staff physician or have a feeling of confidence in, or special attachment to, a certain nurse or a certain nursing shift. After discharge, mothers will occasionally call the Unit to speak with the nurses regarding day-to-day care problems with their infant at home.

Parents who have severe financial problems, those who seem to have negative feelings toward their baby's hospitalization, very young parents, unwed or separated mothers, and those with other special problems are referred to the hospital's Social Service for aid and consultation.

Slides and Tape Session

The atmosphere of the Intensive Care Unit itself often hinders the parents' ability to adjust and relate to the staff, and to listen and concentrate when they are being told about their sick infant. Electronic monitors are frequently triggered by apnea or bradycardia, sounding off audio–visual alarms; respirators may be cycling; chest tube suction pumps and other equipment are noisy. Therefore, parents' attention is often difficult to maintain at the bedside. During the first visit they frequently do not realize what they are being told about their baby.

In an effort to supplement the parents' bedside visit, we frequently attempt to reenforce this experience through a specially prepared tape recording and photographic slide program. The parents are taken to a quiet room by a nurse or physician for the 25-minute program. The recording describes the various problems for which babies are admitted to the Unit, procedures babies frequently must undergo, personnel working with the baby, and modes of therapy and equipment employed. The photographic slides that accompany the recording demonstrate various equipment, procedures, and the like. A typical slide shown to the parents in this session is an incubator. The function of the incubator in maintaining the infant's environment is explained by the recording while the parents are viewing a picture of the incubator. The same is done for umbilical catheters, electrode contacts on the infant's skin, and so forth. Some 30 slides are included with the

25-minute tape recording.* At the end of the session, the nurse or physician answers any questions the parents might have. The purpose of the slide–tape session is to encourage parents' interest in their sick baby, and through education, to allay some of their fears.

A questionnaire was given to the first several couples reviewing this slide–tape session, and in general the comments were favorable.

Nursery Newsletter

Three issues of a quarterly Newsletter have been sent to parents who had babies in the Intensive Care Unit. The goal of the Newsletter is to increase communications among the nursing staff and physicians of the Unit and the parents. Past issues have included such articles as a history of the development of the Newborn Center at St. Marys, information of the Follow-up Clinic, description of the expansion of the Intensive Care Unit, an article describing research on coagulation factors in newborn infants, and an article outlining the Walking Blood Donor Program. This Newsletter is sent to all parents, including those who have had infants die in the Unit.

Meetings with Parents

Although many informal meetings among nurses, doctors, and parents occur during the course of the infant's hospitalization, there are some concerns and ideas which parents share best only with one another. We thought we could encourage a beneficial exchange of ideas by holding group discussions with parents who have had infants in the Intensive Care Unit. As a result, one such meeting was held. There were six couples present and physician and nurse representatives from the Unit. The various occupations represented by the parents were: teachers, housewives, nurses, doctors, persons employed at trades, and students. Some were parents of infants born prematurely, some were parents whose babies were born at St. Marys, while others were from outlying communities. The setting was informal, and there was a spontaneity of comments, questions, and discussion. The group discussion revealed that these parents were quite interested in talking about their own infant. They were anxious to compare their child's development with those infants of other parents who had had similar problems while in the nursery. It was psychologically beneficial for these parents to explore with each other some of their feelings and fears about the physical and mental development of their children who were sick as newborns.

This group also supplied several constructive suggestions for the improvement of the Intensive Care Unit.

PLANNED PROGRAMS

Meetings

We plan to schedule more meetings with parents. Some of these meetings will include only those parents who had infants die in the Unit, and the immediate objectives of such meetings are threefold: (1) to allow these parents to explore their feelings with other parents who have undergone the trauma and strain of an infant dying in a Neonatal Intensive Care Unit; (2) to help the medical–nursing team to understand parents' feelings more completely and thereby be able to supply more meaningful support to the parents when necessary; and (3) to draw from these sessions a parent group interested in meeting with parents who presently have sick infants in the Unit. Their insight would be valuable in helping new parents adjust to the stresses.

There are some who feel that our initial contact with parents of these sick newborn infants should be more inclusive and extensive. For example, we might also talk with the siblings in the family when they first visit the hospital. This would assure them that indeed their mother *did* have a baby after all, and that the parents weren't trying to keep something from them. In cases where the infant is extremely sick and death is practically inevitable, perhaps the meeting should include a psychiatrist who could help the staff evaluate the parents' objective acceptance of death and their possible reactions to it. Social workers of the hospital and community also need to be utilized to a greater extent.

Introductory Letter

Another plan is an introductory letter. This letter will be given to the parents when the transfer ambulance and physician go to outlying communities to bring a baby to the Neonatal Intensive Care Unit in Madison. Essentially the letter will explain the function of the Unit, how babies are cared for, and who is caring for them. The letter will contain concrete information the parents and family can discuss, which may compensate somewhat for the absence of their newborn infant. This will help them realize the danger and seriousness of the baby's illness, and aid them to speak unspoken fears, to grieve, and to communicate with one another.

* This idea was adapted from a similar program carried out for postpartum mothers of normal newborn babies at another hospital by Gordon Tuffli, MD of the Jackson Clinic, Madison, Wisconsin.

Follow-up Clinic

During its first year, our Neonatal Follow-up Clinic has focused on screening and testing infants for developmental milestones and general health. The addition of personnel interested in family dynamics will expand the function of the Follow-up Clinic. Increased efforts are being made to insure that the family meets this person while the baby is in the hospital, and then meets and relates to this same person upon arrival at the Follow-up Clinic. This will increase the number of returns to the Clinic. It also will aid us in early recognition of those parents needing help or support in fulfilling their parent role toward the child who started life under most extraordinary circumstances.

High-Risk Pregnancy Referral Centers

In addition to helping parents in an important psychological sense, there are also ways to aid them medically. One way is through newly instituted perinatal centers, where obvious high-risk pregnancies can be referred for delivery. If the newborn infant then indeed becomes ill, the mother and baby will at least be in the same hospital during the acute phase of the baby's illness.

THE CHALLENGE

The "ongoing programs" and the "planned programs" described above are a beginning, but they clearly do not fulfill all the needs of these parents. More must be done. It is likely that we do not even know of many problems that exist. A recent report has noted an increased incidence in the battered child syndrome in low birth weight infants.[15] Although many factors are involved, these studies suggest an abnormal maternal–child relationship, which might have been negatively influenced or kindled by the prolonged separation resulting from the infant's stay in a neonatal intensive care unit.

These parents of sick newborn infants are returning to many communities in Wisconsin. Physicians caring for these parents and their children are in a unique position to observe the family's reactions to neonatal intensive care. We are sincerely interested in receiving feed-back from physicians who have contact with these families, and we welcome suggestions and comments on how to improve our efforts to help the "parents of severely ill newborn infants."

SUMMARY

The birth of a sick newborn infant and its transfer to an intensive care unit is a family crisis. The normal psychological adjustment to the birth of the infant is not allowed to progress. Infants admitted to a neonatal intensive care unit have a risk of death that is much greater than the regular newborn nursery population. It is invariably difficult for parents to accept this concept. Some parents decline to think about the possibility that their infant might die, or even that the infant is severely ill. Studies have shown that parents who deny the fact that their baby is extremely ill adapt very poorly to the anxiety of having a sick baby. They tend not to talk about it among themselves, to withdraw from the sick infant, and to make no attempt to see the baby or follow its progress. They also suffer more in the event their baby dies.

Since this situation is so stressful for both parents and infants, present hospital practices and policies regulating the care of the mother and infant must be continually reviewed and changed if necessary. We have initiated some projects to aid and support parents of sick newborns in our Unit, and have others in preparation. We submit this for review and would appreciate additional ideas or comments.

ACKNOWLEDGMENT: The authors wish to thank all previous and present members of the University of Wisconsin Department of Pediatrics house staff who have participated in the care of these sick infants and talked with parents; all nurses of the Unit, past and present, for their interest and cooperative effort in parents' programs; those who helped organize the meetings and Newsletter; and St. Marys Hospital Medical Center, Madison, for its cooperation in working to solve a community-related problem. Our thanks also to Miss Mimi Littell for her helpful comments during the preparation of this report.

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Human Sparganosis: Report of a Case in Wisconsin

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SPARGANOSIS IS AN INFECTION caused by migrating plerocercoid larvae of the genus *Spirometra* which is closely related to *Diphyllobothrium*. It was first described by Manson who recovered a sparganum from the tissue of a native of Amoy, China. Later it has been recovered in other areas in the Orient and Africa. In the United States, however, it was first described in 1908 by Stiles[1] in a fisherman from Manatee County, Florida. The sparganum he described was the *Sparganum proliferum* type. The same type was described by Ijima in 1905. The second case in the United States was described by Moore[2] in 1915 in Texas, the *Spirometra mansonoides*.

There are two types or species described; they are *Spirometra mansonoides* and *Sparganum proliferum*. *S. proliferum* differs from the *S. mansonoides* in that *S. proliferum* proliferates and is capable of branching, with subsequent separation, forming another organism. Also it invades not only the subcutaneous tissue and muscle fascia but also other visceral organs, such as lungs, kidneys, and heart.[1]

No adult of the *S. proliferum* has been described or demonstrated up to now. However, there are doubts whether there is another species or just a mutant of *S. mansonoides*.

The generic term sparganum is used when no adult worm is demonstrated or identified and only the larvae are in the tissue. Sparganum which are commonly seen in the subcutaneous tissue and muscle fascia in humans are indistinguishable. If they can be isolated live, they should be fed to dogs or cats to develop the adult.

In 1935, Mueller[3,4,5] described the adult worm of *Diphyllobothrium mansonoides* as about four feet long and living in the intestinal tract of various animals, such as dogs, cats, and bobcats. The ova passed in the feces of the infected animals develops in water into a free-swimming celiated embryo which is ingested by minute crustacean cyclops. In the body of the crustacean the embryo develops into a procercoid larva. The cyclops is ingested by the second host, such as snakes, frogs or field mice, then the larva migrates into the muscular tissue and develops into a larger plerocercoid larva. By eating the flesh of the second host the cat or dog becomes infected by the plerocercoid larva which in two to three weeks matures into an adult worm and completes its life cycle.

Infection of man, which is accidental, was demonstrated in 1941 by Mueller and Coulstan[6] who infected themselves experimentally and found that the larvae grow well in human host. Human infection is by ingestion of infected copepods containing the procercoid larva from the fresh water or by ingestion of raw plerocercoid-infected flesh of birds, frogs, snakes or lastly by local application of flesh of infected animals to opened wounds in the skin which is common practice in some oriental countries.

Case Report

A 26-year-old Caucasian woman, who was born in Milwaukee, Wisconsin, presented to her physician because of a nodule in the right lower quadrant of her abdomen. It had been present for approximately a year. The nodule was asymptomatic most of the time, although occasionally it was slightly tender. She claimed to have two adjacent nodules but the doctor could find only one nodule which was resected and sent to the laboratory with a diagnosis of cyst. She appeared healthy other than the presence of the nodule.

Grossly the tissue received was mostly fat measuring 2.0 cm in diameter. On section a 1.0-cm indurated, red and necrotic area was found.

Microscopic examination revealed a granulomatous inflammatory infiltrate in the fibro-fatty tissue. The inflammatory cells consisted mostly of lymphocytes, histiocytes, giant cells of both foreign and Langhans' types, and a few eosinophils. One large granuloma showed a larva in the center identified as *Sparganum proliferum* (Fig 1). The larva was surrounded with epithelioid cells followed by lymphocytes, histiocytes, and a few eosinophils. There also were scattered giant cells of both types. Three other large granulomas similar to the one described above were seen except for the absence of *S. proliferum* and the presence of central caseating-like necrosis in place of the larva. The granulomas had a tuberculous-like appearance. Scattered in the central caseating-like necrosis, however, were calcified, well circumscribed, ovoid bodies with well deline-

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Figure 1—Longitudinal section of the larva in the center of a granuloma (Hematoxylin and eosin x125).

Figure 2—Larva showing outer cutin layer followed internally by a layer of radially arranged filamentous-like cells. Inside is network of fibrillar-like structure with scattered ovoid amphophilic bodies with nuclei located eccentrically (Hematoxylin and eosin x460).

ated borders, sometimes with concentric pattern. These bodies were interpreted as calcareous bodies which are seen in cestodes and in sparganum.

The larva seen in one of the granulomas (Fig 2) had an outer cutin layer followed internally by a single layer of radially arranged filamentous-like cells with a small round basophilic basally located nuclei. The rest of the larva was composed of a network of fibrillar-like structure with scattered ovoid, well delineated amphophilic structure, some of which had eccentrically located small basophilic nuclei-like structure. Some of these were calcified similar to the previously described calcareous bodies. Arranged parallel to the long axis of the larva were what appeared to be short bundles of broad eosinophilic smooth muscle-like structure with no nuclei. Thin-walled vascular channels were seen also.

Discussion

The patient in this report had never been outside of the Milwaukee and Kenosha, Wisconsin, areas except for a few times in Waukegan, Illinois. The patient claimed not to be fond of eating fish and had not eaten uncooked fish. She had gone wading a few times in Lakes Michigan, Brown, and Paddock; also she had drunk water from the well of her mother-in-law. Examinations of three consecutive stool specimens revealed no parasites or ova. Hemagglutination tests for cysticercosis revealed a 1:6400 titer. Other laboratory examinations were essentially negative. No peripheral blood eosinophilia was noted.

In the authors' knowledge there are only about 43 cases of sparganosis reported at present in the United States, some of which are known through personal communication. Cases such as this one, therefore, are either misdiagnosed, unnoticed, or unreported. All of the reported cases are either from the southern part of the United States or from the northern part when the patients had been in the South previously or outside of the United States. The present case is of interest because the patient had never been outside of an approximate 100-mile area in the vicinity of Kenosha, Wisconsin The only other case of sparganosis reported in Wisconsin is not in a human but in a black fox mentioned in Mueller's report. It is the authors' belief, therefore, that some crustacean in the Wisconsin area, at least in the southeastern part of the State, could be infected with sparganum and that doctors should be more aware of this.

Summary

This is a report of a single case of human sparganosis from the southeastern part of Wisconsin diagnosed from a subcutaneous nodule biopsy. In the authors' knowledge the patient had never been outside an area of 100 miles around Kenosha, Wisconsin, and no other similar case has been reported in Wisconsin.

ACKNOWLEDGMENT: The authors express their appreciation to Doctors Russell M. McQuay and Milka Montiel who helped in the diagnosis and in making the illustrations, respectively.

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DRUG RESEARCH: Arginine

Arginine, an amino acid, has been found useful in the treatment of oligospermia . . . by Dr. A. Shechter and associates of Beilinson Hospital, Tel Aviv, Isreai Israel.

The researchers chose 80 men with varying degrees of oligospermia. Of the total group, 45 had previously been treated with other methods without improvement.

The investigators gave 4 gm arginine to each patient daily.

Pregnancies. They report that a considerable increase in sperm count and sperm motility was produced in 49 of the patients. Eight pregnancies occurred shortly after the arginine treatment.

In 16 of the remaining cases there was a moderate improvement in sperm count and motility, but the other 15 patients showed no improvement.

The researchers conclude that arginine not only increases spermatogenesis, but acting as a triphosphoric acid it also serves as a source of energy necessary for normal sperm motility.—AMERICAN DRUGGIST, Nov. 15, 1971 □

Clinical Experiences in Ultrasonic Scanning of Obstetrical Patients

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IN CLINICAL OBSTETRICS physical examination has been the major means of diagnosing twin pregnancy and hydatidiform mole, estimating fetal maturity, and localizing the placenta. The accuracy of these techniques depends largely upon the skill and experience of the examining obstetrician. Although the utility of x-ray studies is widely known, it has been necessary to restrict such examinations because of possible genetic and somatic risks to both mother and fetus. On the other hand, diagnostic ultrasound has been extensively investigated and no known hazard has been found.[1] For this reason the employment of ultrasonic examinations in the field of obstetrics is of considerable interest.[2] Techniques have been developed which we believe have wide application in obstetrics.[2, 3] Currently we are employing these techniques routinely on a group of selected patients.

Diagnostic ultrasonic tests are based on the pulse-echo principle in which a piezoelectric crystal is used both to send a pulse of low intensity ultrasonic energy into the patient's body and to receive the returning echoes. Interfaces which reflect the ultrasonic energy arise whenever there is a change in density (gm/cm^3) of the medium. The greater the difference between the densities on either side of the interface the larger the percentage of incident energy reflected. Thus tissue-fluid, tissue-bone and tissue-air interfaces all produce echoes. The time elapsed between transmission of a pulse and the reception of its echo is proportional to the depth of the reflecting interface. Echoes which return at a later time are produced by interfaces which are further from the transducer. Thus, it is seen that ultrasound is particularly well suited for measuring distances between interfaces which produce acoustic echoes.

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Because the same transducer is used to both send and receive the ultrasonic signals the reflected energy must return along the same path as the incident sonic energy. Since the major part of the beam is specularly reflected, only interfaces which are approximately perpendicular to the sound beam direction are readily detected by the ultrasonic examination. By changing the entrance angle of the ultrasonic beam it is often possible to obtain echoes from a larger part of the reflecting interface.

Figure 1 shows a schematic view of the type of apparatus used to produce ultrasonic scan pictures. The transducer is coupled to the skin by means of a fluid layer. By moving the transducer in a particular cross-sectional plane along the surface of the patient and rocking it about the normal to the patient's surface at each point, it is possible to map out a cross-section of the anatomy under investigation. Using electronic processing whenever an echo is received at the transducer, dots are placed on an oscilloscope screen at positions corresponding to the positions of the reflecting interfaces in the patient cross-section. In this way it is possible to build up ultrasonic tomograms which are similar in appearance to the cross sections presented in anatomical atlases.

Applications

The easiest ultrasonic pattern to recognize in obstetrics is that of the fetal skull. The cranial structures provide an acoustic interface producing intense echoes which are readily recognized by their circular cross-section and sharp edges. The localization of the head or heads allows one to determine fetal positions and whether multiple pregnancies are present. An accurate determination of fetal position or of multiple pregnancy can be carried out in the most obese edematous patient. If one is unable to obtain an echo from the fetal head, the possibility of anencephaly should be entertained.

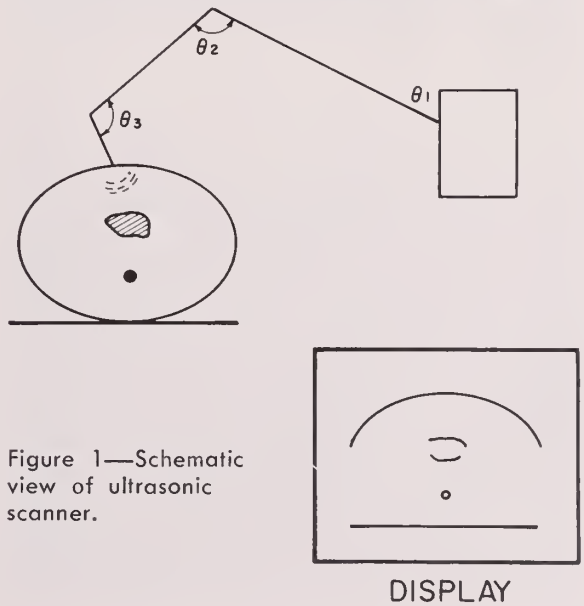

Figure 1—Schematic view of ultrasonic scanner.

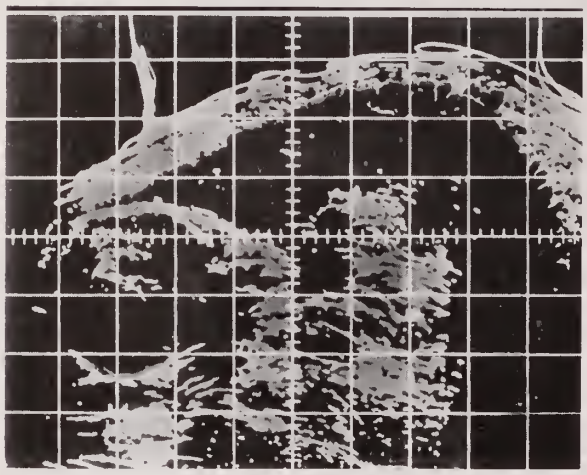

Figure 2—Representative sagittal ultrasonic scan demonstrating the type of images obtained.

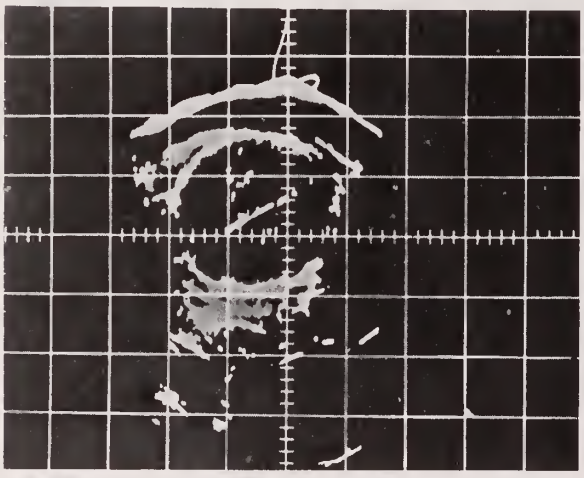

Figure 3—Cross sectional ultrasonic scan taken a level 2.5 divisions to the left of the center of Figure 2.

In addition, by proper choice of the scanning plane, one can determine the fetal biparietal cranial diameter. Our technique for determining the position of fetal head and the biparietal diameter is as follows. With the patient lying supine a sagittal scan is performed along the center line of the patient from the pubic symphysis to the xyphoid process. Figure 2 is a representative sagittal scan. Each division in the picture represents 3 cm. The fetal thoracic outline and cranial echoes are visible. Additional sagittal scans are repeated to the left and to the right of the center line at approximately 2 cm intervals. From the sagittal scans the inclination of the head and its height above the pubic symphysis are noted. A transverse cross-sectional scan is then performed at the level of the fetal head. This level is represented in Figure 2 by the vertical mark 2.5 divisions to the

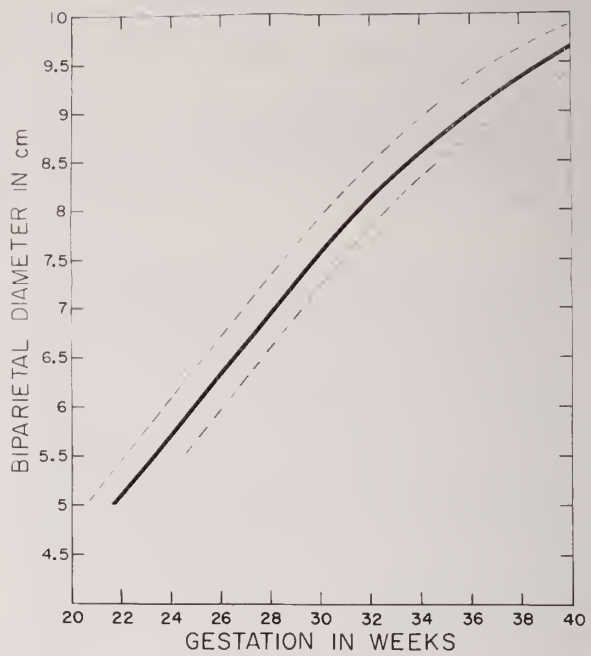

Figure 4—Plot of biparietal diameter determined by ultrasonic examination vs. time from beginning of last menstrual period.

left of the display screen center. The results of this transverse scan are illustrated in Figure 3. Biparietal diameter is then determined from the scan by applying an appropriate scaling factor. The presence of a midline echo produced by the medial sagittal cleft between the hemispheres of the brain insures that one is measuring a true biparietal rather than an oblique diameter. This is because the midline echo can be obtained only if the sound beam is perpendicular to the medial sagittal cleft.

The diameter so determined is then compared with the graph shown in Figure 4 to obtain an accurate estimation of fetal maturity. Campbell[3] has correlated this measurement of fetal maturity and reports an accuracy of ± 8.5 days at the 95% confidence level. By performing weekly scans to determine biparietal diameter one can follow the course of fetal development through pregnancy. Thus, the time of labor induction or cesarean section can be selected with considerable confidence in instances where pre-term delivery is indicated. In addition, the measurement of the biparietal diameter may alert the obstetrician to the presence of a hydrocephalic fetus. Ultrasonic scanning can also be useful in assessing placental function. As long as the fetal biparietal diameter follows the normal development curve (Fig 4) one can assume that the placenta is functioning adequately. Any flattening, or change

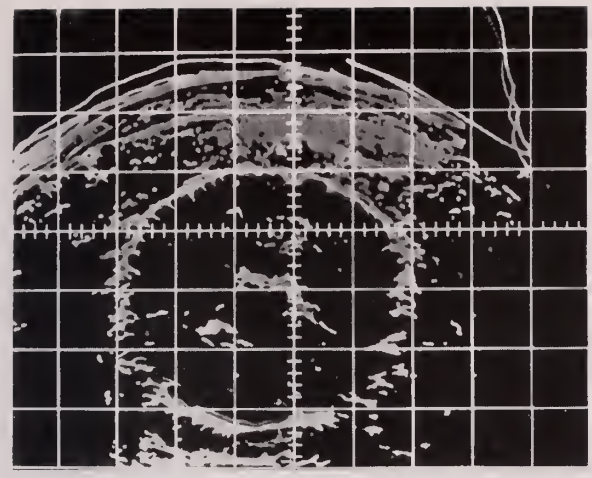

Figure 5—Ultrasonic echogram demonstrating speckled appearance of placenta.

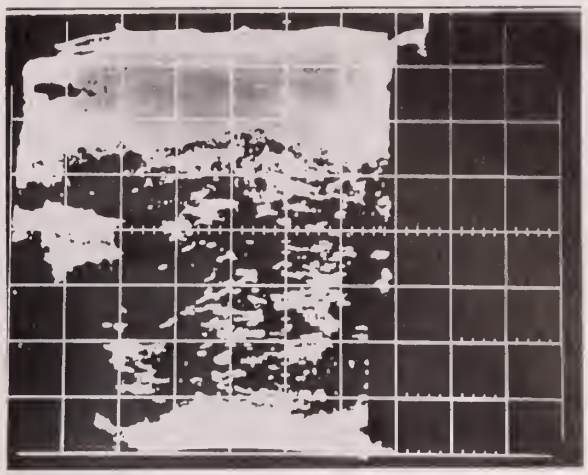

Figure 6—Ultrasonic echogram of hydatidiform mole.

of slope, of the curve may indicate poor placental function. We have followed a series of high-risk pregnant patients in which we measured urinary levels of estriol and fetal biparietal diameter by ultrasound. Our results with urinary estriol have been the subject of a previous communication.[4] We have found that clinical impressions gathered from serial measurements of the fetal biparietal diameter in general are confirmed by serial estimations of urinary estriol. Therefore, we routinely follow all of our high-risk pregnant patients with weekly ultrasonic estimations of biparietal diameter from 20 to 24 weeks on to term. It is also possible with experience to identify the speckled placental echo pattern characterized by the thin outline just below the uterine wall shown in Figure 5. One can often positively identify and delineate the location and size of the placenta.

Another application of ultrasonic scanning in obstetrics is in the diagnosis of a hydatidiform mole. This determination can be made because of the different echo characteristics of the fetus and the mole. Figure 6 presents an echo pattern typical of a hydatidiform mole. The mole gives a uniform speckled appearance with no distinct outlines of fetal parts.

Summary

Ultrasound is a safe and useful tool in obstetrics and gynecology. It is a rapid, painless examination which requires no patient preparation and can be done on an outpatient basis. The combination of ultrasound scanning and serial estriol determinations is valuable in the assessment of placental function.

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Chemosurgery for Malignant Tumors

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Chemosurgery provides complete microscopic control of the excision of cancers of the skin and other accessible structures. The essential steps in the procedure include (1) fixation of the tissues in situ with zinc chloride, (2) excision of layers of the fixed tissues, and (3) thorough systematic microscopic examination of frozen sections cut through the undersurfaces of the excised layers. The process is repeated where cancer is demonstrated microscopically until a cancer-free plane is reached.

Microscopic control is valuable because many external cancers extend unpredictably into the tissues surrounding the grossly visible and palpable mass. By following these inconspicuous outgrowths to their terminations in a selective manner, the chemosurgical technique achieves unprecedented reliability and at the same time is conservative. The operative mortality rate is low, the healing is favorable and free of complications and the method extends operability to many patients with cancers too advanced for hope of cure with other methods.

Facilities and personnel for the use of chemosurgery eventually should be available in every large population center. □

Intrahepatic Arterial Infusion with 5-Fluorouracil

F J ANSFIELD, MD, G RAMIREZ, MD, J L SKIBBA, MD, G T BRYAN, MD, H L DAVIS, JR, MD and G W WIRTANEN, MD, University of Wisconsin Medical Center, Madison, Wis: *Cancer* 28:1147–1151 (Nov) 1971

Prior to the advent of intra-arterial infusion, patients with progressive liver metastases unresponsive to intravenous (IV) 5-fluorouracil (5-FU) were doomed to a rapid downhill course. A significant reversal of this trend was apparent in this series of 200 patients with advanced liver involvement treated with intrahepatic arterial infusion.

Unless the liver condition was too far advanced, the usual procedure was conventional IV 5-FU therapy initially. In 127 patients, when significant progression of the liver metastases appeared, the IV 5-FU was temporarily replaced with a 3-weeks course of intra-arterial 5-FU infusion. Patients with far-advanced disease especially when associated with jaundice were given intrahepatic arterial infusion as the initial chemotherapy which was fairly well tolerated as opposed to conventional IV 5-FU.

Another circumstance in which intra-arterial 5-FU was employed as the initial chemotherapeutic attempt was in the patient who suddenly developed a very rapidly enlarging liver so that it was felt there was insufficient time for a trial with conventional IV 5-FU.

Finally, in patients with liver metastases of tumor types known to be unresponsive to IV 5-FU such as bronchogenic cancer or malignant melanoma, intrahepatic infusion with 5-FU was the initial therapy. With a response, attempts were then made to maintain it with drugs given conventionally and known to have some effect against these tumors.

The 5-FU was dissolved in 5% dextrose with heparin added and propelled by pressure from a Fenwal bag under 300 mm of mercury through a catheter placed percutaneously through the brachial artery. For inpatients the usual dose was 25 mg/kg on 4 successive days followed by 15 mg/kg/day for the next 17 days unless toxicity intervened in which event the 5-FU was withheld for one to several days and then resumed until a total of 21 days of 5-FU infusion was achieved. The catheter was then withdrawn and the patient discharged on weekly maintenance doses of 5-FU of 15 mg/kg.

Our criteria of improvement included: (1) at least a 6 cm reduction in the distance of the liver edge from the xiphoid or costal margin, (2) at least a 50% reduction in the abnormal enzyme levels, (3) a return of the elevated bilirubin to normal, and (4) all these results continue for at least two months.

A total of 61% of the study cases in this series met these criteria of improvement and they had a median survival of 8.7 months from the initiation of the infusion compared to a median survival of 2.5 months for the 39% that failed. Usually, after an initial response, despite weekly maintenance doses reactivation occurred in 4 to 5 months and a repeat 5-FU infusion was given.

Toxicity was infrequent and morbidity from the procedure was reduced with experience. Several instances of mycotic aneurysms and septic embolizations which occurred in the first 100 patients did not occur in the last 100 since the catheter was removed with the first appearance of any infection at the site of the catheter entry into the brachial artery. Then usually the following day a new catheter was placed percutaneously via the brachial artery in the opposite arm. One death occurred in the entire series related to a massive superior mesenteric artery thrombosis from remanipulation of a catheter into a right hepatic artery which arose from the superior mesenteric artery.

That these patients were least likely to respond is evident from the patient selection yet, despite this, gratifying responses were observed in 61% of the cases with a significant increase in survival which will be further enhanced by earlier repetition of the infusions as soon as it becomes apparent that reactivation of the disease is occurring despite weekly 5-FU maintenance therapy. □

Clinical Center Study of Patients with Australia Antigen Positive Hepatitis

The cooperation of physicians is requested in the referral of patients with acute viral hepatitis, Australia antigen positive, for studies being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health, Bethesda, Md.

Needed are patients for in-patient studies of immunologic reactivity. Preference will be given to those individuals who are in the early stages of the disease. Patients who are addicted to drugs, who have chronic hepatitis, or who have any other serious chronic disease will not be considered. Patients who have severe hepatitis with impending coma or abnormal prothrombin time would not be good candidates.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to this study may write or telephone: Paul H. Plotz, MD, Clinical Center, Room 9N-210, National Institutes of Health, Bethesda, Maryland 20014. Phone: 301–496–1474. *Or,* Sau Agus, MD, Clinical Center, Room 9D-15, National Institutes of Health, Bethesda, Maryland 20014. Phone: 301–496–4201. □

Management of Depression

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

DEPRESSION IS THE UNDERLYING problem of a large segment of the patient population seen in the daily practice of medicine. It can occur at any age and presents in diverse forms. Such presenting complaints as fatigue, apathy, insomnia, headache, or backache are many times indications of depression. It frequently accompanies or follows traumatic injury, childbirth, surgery, and acute infections. The clinical syndrome of depression is estimated to occur in the general population at a prevalence rate of 3 to 4 percent.

The term "depression" is used to signify a transient mood state, a symptom, and a syndrome. As a mood state it occurs commonly in the life of each person as a temporary period when one's spirits are low, with feelings of gloom, sadness, or dejection. Depression is also noted as a common symptom accompanying physical trauma, disease states, or life crises. For purposes of clinical management it is important to distinguish the presence of depression as a mood state or a symptom from its existence as a clinical syndrome.

Depression develops in an infant with inadequate mothering contacts. With severe lack of mothering the infant fails to thrive and if sustained the condition becomes irreversible. Adolescents often experience depression as part of their identity crisis. During periods of isolation, loneliness, and alienation from other family members, the adolescent is vulnerable to the intensity of suicidal despair accompanying depression. Suicide is a substantial hazard during this period of impulsivity.

Depression is readily recognized if the physician considers it in his differential diagnosis. With patients who present the following types of problems, the doctor should think of depression as a diagnostic possibility: multiple symptoms in multiple organ systems; non-physiologic symptoms; symptoms resistant to standard medical management: weakness,

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apathy, fatigue, and sleep disturbance. In the syndrome of depression many of the following symptoms are described, regardless of the specific patterning of the disorder: a persistent depressed mood; disturbed sleep—usually insomnia with early morning awakening; decreased appetite with weight loss; self-blame for actions affecting self or others; altered activity level—usually decreased but may be increased; loss of interest in usual activities, including sex; constipation; hopelessness and pessimism.

Diagnostic Categories

The most common depressive syndrome is the depressive neurosis. The patient's history reveals a recent loss in that person's life—usually separation from another person, although it may be the loss of an object or a situation, such as losing a job, money, status, or moving from a location. The individual reacts to that loss by becoming depressed as a defense against the anxiety that would otherwise be strongly felt. This type of depression is usually not of great intensity but it may mask the presence of an organic disease that is causing the depression. The depression may not be recognized when it occurs with another illness and the depression may impede the progress of the patient's convalescence. This type of depression is commonly found during aging concomitant with deteriorating physical and mental capabilities.

The involutional depression is seen in the fifth and sixth decades of life with an onset in males about one decade later than for females. The relationship of the illness to the endocrine changes characteristic of this period of life is unclear. It typically occurs in highly organized conscientious perfectionistic persons at the time they confront present or pending diminution in their bodily capacities. Many but not all such depressive persons have much agitation, restlessness, and anxiety with a high risk of suicide.

The psychotic depression is a severe disabling symptom state related to prior environmental stress. The patient reports marked hopelessness, suicidal ideation, guilt over actual or fantasied prior behavior, delusions, sometimes hallucinations, weight loss, awakening during the night, and very severe symptoms early in the day.

The manic-depressive illness is a recurrent pattern of mania or depression or both. There is usually a family history of the illness. Each episode tends to remit after a time with or without treatment with return to the premorbid personality pattern. The mania is characterized by an elated mood, hyperactivity, impaired judgment, talkativeness, and anger with little provocation. The depression is most noted for its periodicity and severity.

Depression may accompany other forms of mental illness, such as with organic brain disorder or as an integral part of the symptoms in the schizoaffective type of schizophrenia. In the latter either the manic or depressive form may be present along with usual schizophrenic symptoms of severe disturbances in behavior and ideation. Antidepressant drugs must be used cautiously in schizophrenic patients since they may exacerbate the psychotic symptoms.

The greatest risk in depression is suicide. Every depressed patient should be evaluated for suicidal risk and treated accordingly. Those with severe depressive symptoms or recovering from them—the aged, individuals with family disruption or social dislocation, persons with a history of prior suicidal attempts, and those with thoughts of the specific means for attempting suicide—are particularly high risk. A number of suicidal persons also present a homicide hazard, especially to their intimates. The treating physician should provide suicidal patients with an organized plan of therapeutic action, consider hospitalization, use antidepressant drugs wisely and remain psychologically and temporally available in a supportive relationship. If in doubt psychiatric consultation should be obtained promptly.

Management

The management of depression is a multifold process that may include antidepressant drugs, psychotherapy, electroshock therapy and behavioral-milieu hospital care. It must be remembered that barring successful suicide depression is largely an illness that is self-limited in duration.

Psychotherapy in most instances of depression is not directed toward providing insight and may be performed by most concerned clinicians. The patient needs to know that he is supported by others who provide encouragement and that his life problems are not insuperable. It is more important who the therapist is as a person rather than specifically what he says, namely it stresses that support comes from recognizing a relationship with someone who is interested and desirous of hearing about the difficulties faced by the patient. The professional warmth and desire to be helpful goes a long way in letting the patient talk about what he feels in his isolation and often desperation. The physician's quiet demeanor, directness, firmness, and sense of optimism help provide the reassurance that words directly fail to convey.

Electroshock therapy is the most successful form of treatment in severe depressions with high suicidal risk. However, the risk of complications, the usual accompaniment of a several-week convalescence with amnestic impairment and the reluctance of most physicians to use it except as a measure of last re-

sort, following failure of other treatment modalities and with very high suicidal risk patients, make it less often used than previously.

Persons with severe depressions are usually hospitalized and a behavioral-milieu program may be instituted. This consists of a supportive environment that helps protect the patient against his own suicidal impulses. Removal from the pressure of external stresses, involvement of family and friends, and use of a structured program that aids the patient in dealing with his emotions of anger, helplessness, and ambivalence are complementary to the other therapeutic modalities.

Pharmacotherapy

It is axiomatic in medical therapy that a multitude of therapeutic approaches for a given disorder reflects the failure of any one of the therapies to be sufficiently effective that it has pre-eminence. Such is the case with the use of drugs in treating depression, for there are highly conflicting reports of drug efficacy in medical literature and multiple preferential treatment regimens used by different clinicians. In controlled studies of drug treatment for depression using placebos most but not all of the drug effect can be accounted for by a placebo effect, and with severe depressions electroshock therapy is the most effective treatment method. The drugs provide symptomatic relief over a sustained period but are not curative of the depressive illness. The tendency of depressions to spontaneously remit and to be responsive to social and psychological influences makes therapies for depression particularly difficult to study. Further complicating this situation is the influence on antidepressant drug metabolism by such factors as genetics and interactions with other drugs. Studies of tricyclic drug metabolism reveal widespread variations in blood levels following similar single doses of a given drug in different patients.[1]

In general, the depressive aspects of neurotic depression do not respond well to antidepressant medications, or in other words, such depression responds equally well to placebo as to the active drug. However, sleep disturbances and anxiety in neurotic depressions are benefitted by either tricyclic drugs or minor tranquilizers. Psychotic depressions in about two out of three persons improve substantially with antidepressant drugs. Tricyclic compounds are the drugs of choice with monoamine-oxidase inhibitors a second choice. Some clinicians believe that if anxiety is prominent in a "psychotic depression" a phenothiazine, particularly thioridazine (Mellaril®), may be equally helpful to relieve the symptoms.[2] As the terminology is used here the term "psychotic depressions" refers to involutional and manic-depressive depressions as well as to the label of psychotic-depressive reaction. Stimulant drugs, such as amphetamines and methylphenidate (Ritalin®), are only temporarily helpful and the rebound effect in depressions is such as to make their usefulness very limited. Lithium carbonate in some patients appears useful in maintaining the stability of manic-depressive patients over an extended period, although it does not relieve symptoms of a current depression as it does a manic episode.

The major tricyclic drugs are imipramine (Tofranil®), desipramine (Norpramine®, Pertofrane®), amitriptyline (Elavil®), nortriptyline (Aventyl®), protriptyline (Vivactil®), and doxepin (Sinequan®). These compounds chemically resemble phenothiazines but only amitriptyline and doxepin generally produce significant sedation. Improvement occurs slowly, usually in from one to four weeks, and the drug should then be continued for a period of at least three to six months. Gradual drug withdrawal thereafter with observation of the patient's progress may be successfully accomplished if the patient has passed the depressive illness. If he has not, then continued medication remains necessary for an extended period.

A wide range of untoward effects may occur with tricyclic drugs, the most common of which are anticholinergic effects mixed with autonomic actions such as hypotension, dry mouth, constipation, hyperhidrosis, blurred vision, urinary retention, and rare adynamic ileus. A first degree A-V block may be noted on the electrocardiogram and rarely there may be agranulocytosis or cholestatic jaundice produced by some of these compounds. Their use is contraindicated in patients receiving guanethidine (Ismelin®) or methyldopa (Aldomet®), or when patients have paroxysmal tachycardia, angina pectoris, or congestive heart failure. They should be used cautiously in patients taking medication to reduce their elevated blood pressure, in the elderly and by persons with glaucoma, epilepsy, or with markedly impaired liver function. They should not be given with or within two weeks following the use of monoamine-oxidase inhibiting drugs due to the high risk of adverse reactions, although some clinicians have reportedly combined them in low dosage to successfully manage some depressive illnesses.[3]

The major monoamine-oxidase inhibitors (MAOI) are tranylcypromine (Parnate®), isocarboxazid (Marplan®), nialamide (Niamid®) and phenelzine (Nardil®). They are generally considered as less effective than the tricyclic drugs and they have potentially more hazardous adverse effects. Tricyclic drugs should be tried first to relieve depression unless the patient has a prior history of symptomatic control of depression with one of these compounds. Their pattern of slow responsiveness and need for extended use is similar to the tricyclics.

The most usual adverse effects from MAOI use are the autonomic and anticholinergic effects reported earlier for the tricyclic agents. The hypersensitivity reaction of hepatitis caused the removal from the drug market of several hydrazine MAOI drugs and it can occur with the remaining compounds (isocarboxazid, nialamide, phenelzine). A rare effect from the same drugs is leukopenia. All of

the MAOI drugs can cause paradoxical hypertension but the most common offender is tranylcypromine. In that condition severe headache, palpitation, nausea, and vomiting result and it can lead to subarachanoid or intercranial hemorrhage. These reactions may be caused by the interaction of the drug with such foods as aged cheeses, broad beans, chicken livers, pickled herring, chocolate, and yeast extracts. Patients on these drugs should also avoid alcoholic drinks and drugs with pressor substances such as certain antihistamines, cold remedies, and anorexiants.

MAOI drugs should be used cautiously with drugs whose actions they may potentiate including insulin, phenothiazines, barbiturates, morphine-like analgesics, antiparkinson drugs, thiazide diuretics, nitrofurans, methyldopa, procaine and adrenergic compounds. If it is necessary to use them together a reduced dosage of each drug is advisable. As with tricyclic drugs ordinary caution should be exercised if they are required during pregnancy, and the two types of compounds should not be used together. Their use in elderly persons should be cautious as with those persons having epilepsy, glaucoma, or severe liver damage. MAOI drugs are contraindicated in persons with hypertension, pheochromocytoma, cardiovascular disease, or known or suspected cerebrovascular defects.

A consensus among clinicians is lacking as to which drugs in either the tricyclic or MAOI classes of drugs are most effective and with fewest adverse reactions as compared to other members of the same group. Individual preference by the physician is often the determining factor as clinical studies vary widely on this matter.

The use of amphetamines for treatment of depression is seldom indicated; and when psychomotor stimulant therapy is needed, methylphenidate (Ritalin®) is the drug of choice. The use of such stimulants in hyperkinetic children or in those with certain learning or behavioral disorders and with narcolepsy is reportedly often effective on a symptomatic basis. Stimulants are not advisable as a means of overcoming the fatigue of overwork or physical exertion, energizing after use of sedatives or to gain euphoria. Other stimulant drugs, pipradrol (Meratran®) and deanol acetamidobenzoate (Deaner®), have not been demonstrated through controlled studies to have significant effectiveness as antidepressant drugs.

Summary

Depressions are common in medical practice and they frequently co-exist with medical and surgical problems. Antidepressant drug studies are mostly poorly controlled but the drugs are effective in many seriously depressed patients. Symptomatic relief includes lessening the intensity of symptoms more rapidly than expected through spontaneous remission, reducing the risk of suicide, elevating mood, improving appetite and sleep patterns, lessening hopelessness and promoting social and vocational adaptation. Tricyclic drugs are the compounds of choice since monoamine oxidase inhibiting drugs are both more hazardous and less effective.

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Clinical Center Study of Patients with Malignant Melanoma, Sarcoma of Soft Tissue or Bone

The cooperation of physicians is requested in the referral of patients with melanomas and sarcomas of soft tissue and bone for studies being conducted by the National Cancer Institute's Surgery Branch at the Clinical Center, National Institutes of Health, Bethesda, Md.

Needed are patients with primary tumors and those with limited metastases which are amenable to primary surgical treatment. Selected patients will be admitted to combined surgery, chemotherapy, and immunotherapy protocols.

Patients treated will receive adjuvant therapy according to criteria based on tumor anatomic location and histologic type. Immunologic studies will be performed preoperatively and at intervals postoperatively to monitor the effects of adjuvant therapy and provide sensitive means of followup for earlier detection of recurrent tumor.

Upon completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone: ALFRED S. KETCHAM, MD, Clinical Center, Room 10-N-116, National Institutes of Health, Bethesda, Md. 20014; tel.: 301–496–4164. □

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The Third Hemostatic Vitamin

ARMAND J. QUICK, MD
Milwaukee, Wisconsin

THE PROBLEM OF HEMORRHAGE had its origin back when primitive man left his tropical surroundings, where his diet was rich in vitamin C, and settled in the temperate zone with its long winters that yearly drained his vitamin C stores. This dietary deficiency likely took innumerable lives long before man cut himself with his inventions—spears, arrows, and swords—and long before he ventured out on lengthy sea voyages. No records exist that date to when this bleeding state, which was caused by a dietary deficiency, was first recognized as a disease.

Of relatively recent origin is the term 'scurvy.' In 1730, Kramer, a Hungarian physician, made the significant statement: "Scurvy is the most loathsome disease in nature; for there is no cure for it in your medicine chest; no, nor in the best furnished apothecary's shop. If you can get green vegetables or the juice or pulp of oranges, lemons or citrons, you will without other assistance, cure this dreadful evil." It took, however, two centuries before this profound therapeutic directive came to its full fruition and, shall we say, to its super fruition, with the advocacy as a preventative of the common cold.

Now, scurvy is firmly established as a deficiency disease. The lack of this specific vitamin (C) is responsible for a breakdown of the mesenchymal tissue, thereby causing bleeding, even though the blood coagulation system and the platelets are normal. In this disorder, all hemostatic tests are normal except for the tourniquet test, just as Hess and Fish[1] found it to be positive in their pioneer investigation

From the Hemostasis Research Laboratory, Medical College of Wisconsin, Milwaukee.
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Reprint requests to: Armand J. Quick, MD, Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis. 53233.
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of infantile scurvy. The pathognomonic means to establish the diagnosis, which is the absence of ascorbic acid in the blood, has been a relatively recent development.

It is from this first bleeding disease in man that much can be learned about the complex mechanism of hemostasis, foremost of which is the required maintenance and repair of tissue. But this valuable lesson should not be confined to scurvy, because, when the second antihemorrhagic food accessory—vitamin K—was discovered and came into its own, it was again observed that this vitamin is likewise needed in the maintenance and repair of tissue.

Vitamin K

At the beginning of this century, the physiologist knew practically nothing of hemostasis and the pathologist very little more. The surgeon, equally ignorant of any basic knowledge of hemostasis, ignored both but mechanically with the tampon, the ligature, and the hemostat, together with the ego that every good surgeon needs, was not deterred from cutting into human flesh. Even as late as 1958, it was written that a "surgeon's method of achieving hemostasis is still the highest criterion of his skill." What none clearly recognized was that hemostasis is such a perfected mechanism, that normally bleeding can be so effectively controlled mechanically, that it is taken for granted. Yet, in 1900, the surgeon was well aware that he was apt to lose, from uncontrolled postoperative bleeding, one out of every seven patients who had a biliary obstruction. None of his mechanical skill was of any avail to correct this.

In this dark period there occurred three events, completely independent of each other, and which, in retrospect, may be described as momentous for the progress in hemostasis. Hemorrhage in chicks was being produced by feeding a synthetic diet by Dr. Dam in a nutrition lab in Europe and by another group in Ontario. On the plains of Ontario, Schofield, and in North Dakota, Roderick, were studying a strange bleeding state in cattle that they traced to a toxic principle in spoiled sweet clover hay. Thirdly, in a corner of a laboratory of the Fifth Avenue Hospital, New York, a clinical chemist hired to assist the two surgeons—Doctors Frederick Bancroft and Margaret Stanley-Brown—in studying thrombosis, developed a new clotting test which came to be known as the one-stage prothrombin time.

All this culminated, *first,* in the recognition of a new vitamin named K, *second,* in the identification and isolation at the University of Wisconsin of the toxic agent from spoiled sweet clover hay and given the name of bishydroxycoumarin (Dicumarol®), and, *third,* in the development of a new diagnostic tool—the prothrombin time. Results of this triad are now history. The availability of vitamin K together with the simplicity of the prothrombin time in diagnosing vitamin K deficiency and in evaluating therapy led quickly to the almost complete elimination of two serious bleeding states—the hemorrhagic disease of the newborn infant and the postoperative bleeding in jaundiced patients. In a similar manner, the introduction of Dicumarol® as a possible prophylactic drug against thrombosis proceeded smoothly because the one-stage prothrombin test served as a reliable guide for monitoring dosage. The early clinical studies on Dicumarol® in various clinics, of which Columbia Hospital was one, that used the standardized prothrombin test with a suitable thromboplastin reagent, have never been excelled in reliability.

The statement that "In 1935 A. J. Quick presented his one-stage method of prothrombin in blood. At that time it could not have been foreseen that in doing this, he opened a new era of blood coagulation research" is not strictly correct. Equally important in initiating this renaissance in hemostasis were the discovery of vitamin K and the solution of the spoiled sweet clover hay disease that led to the identification of the toxic principle—Dicumarol®. The impetus that this triad gave to hemostatic research resulted not only in fundamentally established facts but also in many theories that led to misinterpretations. Again, one of the most pertinent facts that was overlooked and underestimated was that vitamin K is a growth vitamin needed also for tissue maintenance and repair. The fast-growing chick requires daily over 100 times as much vitamin K on the basis of body weight as does the adult dog.[2,3] Vitamin K is so widely distributed and its maintenance dose is so minute in the adult that a lack rarely, if ever, occurs after the early neonatal period as the result of a dietary deficiency. When it does happen in adult man, it is due almost exclusively to malabsorption from the gastrointestinal tract or to antagonists to vitamin K, of which Dicumarol® is the prototype. It bears repeating that the type of bleeding seen in vitamin K deficiency is characteristic of tissue breakdown—spontaneous and deeply intramuscular.

The second major observation was that a drug such as Dicumarol® is a vitamin K antagonist and that it acts on the basis of the law of mass-action. It is a reversible reaction which can be most simply presented by a diagram (Fig 1); the enzyme which requires vitamin K is designated Æ K. The K component of this enzyme can be supplied by the simple 2-methyl-1,4-naphthoquinone (menadione) or by the more complex compounds occurring in

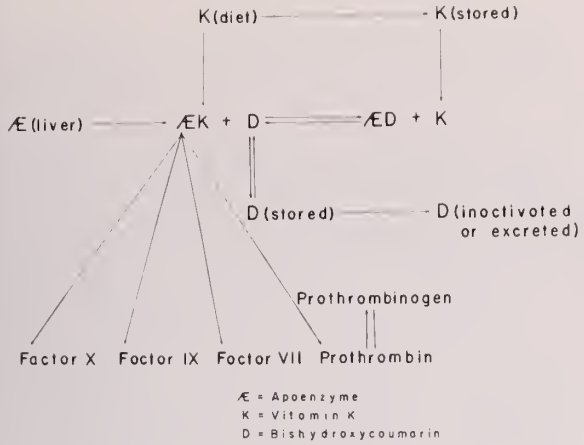

Figure 1—The vitamin K-dependent synthesizing enzyme system and its depression by Dicumarol®. The enzyme (AE K) is responsible for the production of prothrombin, factors VII, IX, and X. Its depression by Dicumarol® follows the law of mass action.

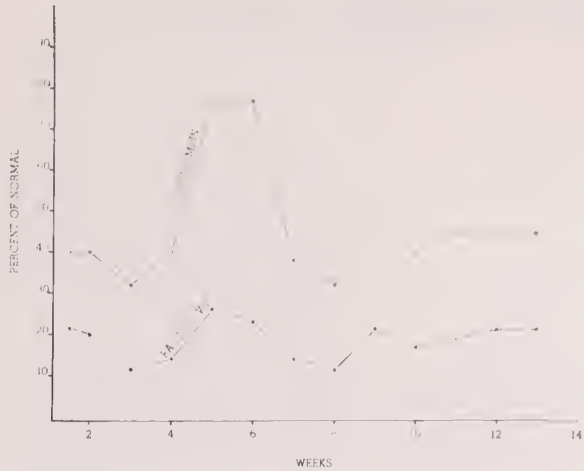

Figure 2—Plasma level of prothrombin and factor VII in a patient receiving Dicumarol®.

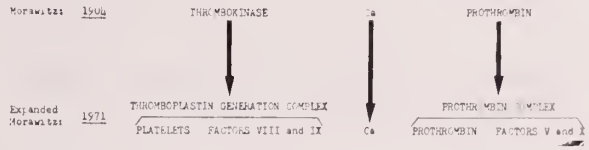

Figure 3—Original and the expanded blood clotting theory of Morawitz. In this intrinsic reaction factor VII is not required.

green plants and in bacteria designated vitamin K_1 and K_2, respectively. Dicumarol® and all the other oral anticoagulants act by replacing the K in Æ K by an inactive component and designated D in the diagram. The Æ K activity can be reduced at will with a compound such as Dicumarol® and the effect accurately measured with the one-stage prothrombin time.

Of great significance was the observation that when Æ K activity is depressed, not only prothrombin is reduced but also other factors, particularly factors VII, IX, and X. Strikingly, it is factor VII which is depressed most. Perhaps it is more correct to state that the production of all four factors is depressed equally but the concentrations as measured in the blood represent the balance between production and utilization or metabolic turnover. Therefore, because the consumption rate of factor VII is highest, its concentration is reduced most. Prothrombin runs parallel but is reduced much less (Fig 2).

Factor VII is unique and is unlike the other vitamin K-dependent clotting factors—prothrombin, factors IX and X—in that it is not a true blood clotting factor. Even in its absence, the clotting time, the prothrombin consumption time and the thromboplastin generation test, all of which measure intrinsic coagulation, are normal. Nevertheless, patients who genetically lack factor VII are very severe bleeders, yet the clotting tests just enumerated are entirely normal. Strikingly, however, the one-stage prothrombin time is not only markedly abnormal but it serves as a sensitive and quantitative measure of factor VII. To find the explanation to this seemingly paradoxical situation, one must critically re-examine the blood clotting equations for the answer.

Obviously, the original Morawitz equation is inadequate. What Morawitz called thrombokinase was actually not a substance but an activity which is generated during coagulation and called intrinsic thromboplastin. Likewise, his prothrombin was not solely prothrombin but it included several accessory agents, principally factors V and X (Fig 3). Innocently and unaware of its consequences or its ultimate significance, I altered the clotting reaction by adding a tissue extract and, thereby, created the one-stage prothrombin test. Fortunately, I selected the right source for tissue thromboplastin, namely, rabbit brain cleared of all visible vascular structures and purified by dehydration with acetone, thereby obtaining a highly potent preparation of uniformly constant activity which was more than a mere reagent. It was a true tissue component.

While tissue thromboplastin appears to be inert *in situ,* it figuratively becomes clotting dynamite when free in the blood. Thus, when a small amount is added to freshly drawn human blood, it brings about clotting in 12 seconds, whereas without it, 4 to 8 minutes are required for a solid clot to form. It is therefore understandable why the prothrombin time is often called the quick test.

Clearly, the one-stage prothrombin time established the significance of factor VII. When it becomes depressed by the lack of vitamin K or by a drug such as Dicumarol®, or in a severe hereditary state, a serious bleeding condition occurs which is characterized by spontaneous hemorrhage. This cannot be due to defective blood clotting since this process is normal, as measured by the acknowledged tests such as the clotting time, the thromboplastin generation test, and the prothrombin consumption

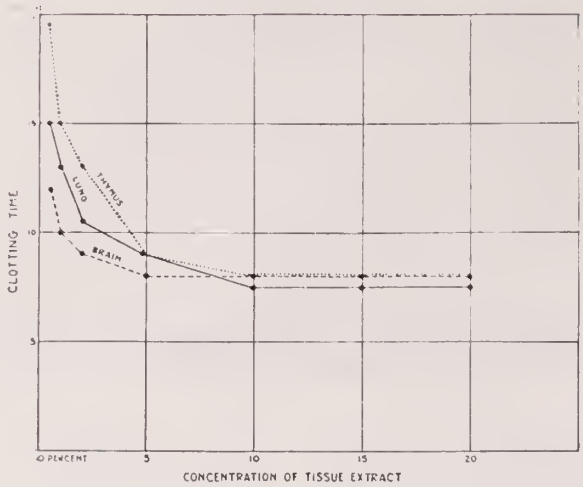

Figure 4—Thromboplastin concentration in various tissues of the rabbit.

time. The thromboplastin of the tissues likewise is normal, even in hemophilia, but this does not prevent traumatic hemorrhages. This leaves but one obvious conclusion: factor VII with tissue thromboplastin is needed for tissue repair and maintenance, independent of intrinsic blood coagulation. To supply adequate amounts of factor VII, vitamin K is essential and the only gauge for the adequacy of factor VII is the standard one-stage prothrombin time.

Tissue Thromboplastin

It is certain that in tissue repair and maintenance, thromboplastin is just as important as the factors already discussed, but tissue thromboplastin has been taken for granted and regarded as a nebulous type of substance to which a modicum of attention has been given. Yet, in 1936, using the principle of the one-stage prothrombin time, I assayed the concentration of thromboplastin in three different tissues of the rabbit and found it surprisingly high and relatively constant[4] (Fig 4). Why these findings should not have stimulated further investigation is difficult to explain. Much confusion resulted in attempting to equate platelet activity with that of tissue thromboplastin. Most misleading was the view that thromboplastin was locked up in platelets and liberated by a hypothetical thrombocytolysin.

In 1947 the enigma of the relationship between the platelets and thromboplastin was solved by the development of the prothrombin consumption time test,[5] and it would have cleared the confusion had it not been for the unwarranted modification of my original test which robbed it of much of its true and potential value.

The prothrombin consumption time test, like its predecessor—the one-stage prothrombin time, is simple both in theory and in technical procedure. Blood is clotted under standardized conditions and the prothrombin determined in the resulting serum. In the original study it was found that only a minute amount of prothrombin was consumed when either blood from a severe hemophiliac or normal plasma depleted of platelets by centrifugation was clotted. Significantly, when platelet-rich hemophilic plasma was mixed with normal platelet-depleted plasma and clotted, the prothrombin consumption was normal. From these results, the obvious conclusion was drawn that platelets contain a constituent which reacts with the factor present in normal plasma but lacking in hemophilic plasma, now known as factor VIII, but which at that time I had named thromboplastinogen. This was the origin of the concept of the generation of intrinsic thromboplastin which six years later Biggs and Douglas[6] confirmed by a modified thromboplastin generation test, incorporating an additional factor now designated by the Roman numeral IX but initially called the Christmas factor and PTC.

Both the prothrombin consumption time and the thromboplastin generation test[6] could be made specific to detect and measure a functional defect in platelets by adding normal platelets. But the task of isolating and washing platelets was tedious and, therefore, it was human to look for a platelet substitute.

Such a platelet substitute was found in hemolyzed erythrocytes[7] and the reagent made from it was named hemolysate, or erythrocytin, and introduced in the prothrombin consumption test to make it specific for a platelet dysfunction determination. It was even more potent than a platelet extract in both the prothrombin consumption time and the thromboplastin generation test.[6] At about the same time Bell and Alton[8] found that a chloroform-extract of acetone-dehydrated brain tissue could substitute for platelets in the test of Biggs and Douglas but, in this modification, the test was no longer suitable for detecting a platelet dysfunction. It was soon found that an extract of soybean meal was also suitable as a platelet substitute in the thromboplastin generation test,[9–13] and later, it was also applied to the prothrombin consumption time test as a replacement of my hemolysate reagent.

It was provocative to note that three body tissues —the platelets, erythrocytes, and dehydrated brain —should all provide a factor that functions in the generation of intrinsic thromboplastin as measured by two independent procedures—the prothrombin consumption time and the thromboplastin generation test. What seemed even more significant, and in-

congruous, was that an extract of a plant product—soybean meal—possesses the same basic property. Fortunately, a simple but ideal assay method was available: the prothrombin consumption time, using normal platelet-depleted human plasma as the assay medium. In such a system the only known missing factor is the platelet. By adding increasing quantities of platelets, the prothrombin consumption increases proportionately but only when the platelets are allowed to liberate their clotting factor (Fig 5). The same straightline proportion is obtained on using hemolysate, a chloroform extract of acetone-dehydrated brain (the Bell–Alton reagent), and a water suspension of an alcohol-insoluble extract of soybean meal (commercially marketed as Inosithin®) (Fig 6). The straight-line proportion was also obtained when my thromboplastin reagent (acetone-dehydrated rabbit brain) was added in increasing amounts.

These results clearly suggest that platelets contain a specific agent needed in the generation of thromboplastin and that the same factor is present in the erythrocyte and in other body tissues of which acetone-dehydrated brain tissue is the most suitable for experimental study. The high potency of the soybean extract is strong evidence that the platelets may obtain their clotting factor from exogenous sources.

This presents the exceedingly important question: Can the human organism synthesize this platelet clotting factor or must it be obtained from exogenous sources? If the body cannot produce this factor endogenously, then the agent in soybeans must be considered to be a vitamin. However, this contention must be established experimentally by demonstrating that a deficiency of this clotting factor in platelets can be corrected by supplying an excess amount of the soybean principle and noting an unequivocal improvement in the prothrombin consumption time.

The opportunity to test this hypothesis came rather unexpectedly. A patient with hereditary thrombopathic-thrombocytopenia wanted some insurance papers filled out. I had studied this man since 1951 and, even though he was clinically well, his father, who had the same defect, suddenly had gastric hemorrhages which quickly worsened and in two years terminated fatally in a massive gastric hemorrhage. As seen from Table 1, the bleeding time and prothrombin consumption test had remained abnormal over the 21 years, despite the lack of symptoms. When I found on a new study that his bleeding time was significantly prolonged, I decided to test the effect of the soybean principle. I restudied him carefully ten days later and then supplied him with the therapeutic agent. The results of this experiment are best presented by a composite picture (Fig 7) showing the bleeding time results which were reduced to nearly normal. After another week of therapy, the test was entirely normal. This was the first normal bleeding time he had had in

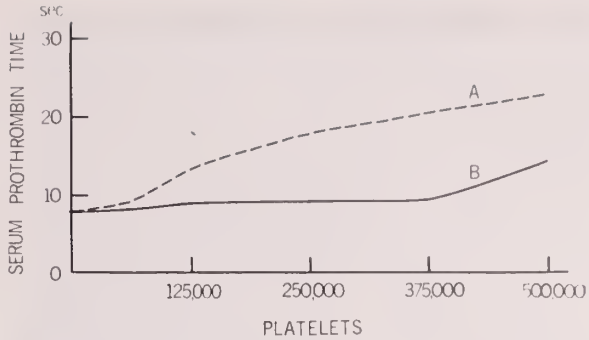

Figure 5—Relation of the number of platelets to prothrombin consumption. In A, the serum prothrombin was measured after clot retraction was completed, while in B, the fibrin clot was removed continuously as it was formed.

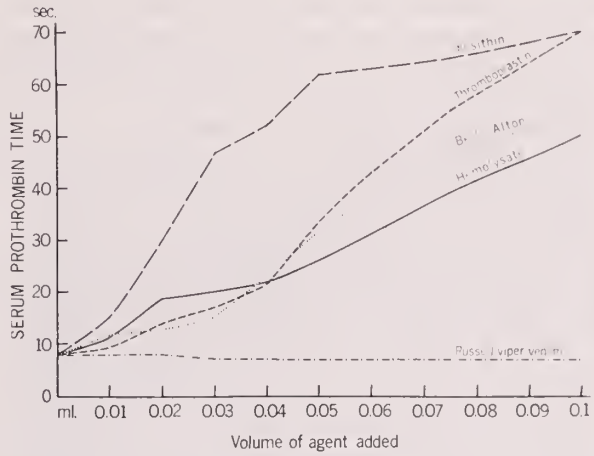

Figure 6—Effect on the prothrombin consumption time produced by adding increasing amounts of thromboplastin (extract of acetone-dehydrated rabbit brain), hemolysate (extract of hemolyzed erythrocytes), the Bell–Alton reagent (chloroform extract of acetone-dehydrated brain tissue) and Inosithin® (phospholipid fraction of soybean meal). It is to be noted that Russell viper venom did not cause consumption of prothrombin.

TABLE 1—*Variations observed in the prothrombin consumption time, the platelet count, and the bleeding time in a case of hereditary thrombopathic thrombocytopenia with telangiectasia.*

DATE OF STUDY	PROTHROMBIN BASIC (SEC.)	CONSUMPTION TIME WITH HEMOLYSATE (SEC.)	PLATELET COUNT	BLEEDING TIME (MIN.)
9-29-51	13		130,000	10
12-2-51	12		66,000	15
1-21-57	14.5	85	157,000	10
2-17-57	11.5	100	90,000	9
7-19-58	13	37	42,000	7.5
6-28-61	13	91	75,000	16
11-27-61	10	75	120,000	7
9-25-62	13.8	50	123,000	>25*
11-30-62	10	80	87,000	8

*Several hours after taking a drug containing aspirin.

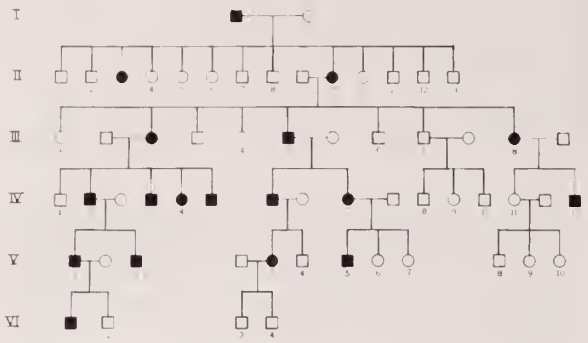

Figure 7—Pedigree of the case of hereditary thrombopathic thrombocytopenia.

the 21 years I had studied him. Oddly, his prothrombin consumption time did not improve as rapidly or as spectacularly as did his bleeding time, but, eventually, it too was brought into the normal range which had never before occurred.

The findings obtained on this patient seemed so significant that duplicating them on a second patient seemed most urgent. Fortunately, in my repertoire of cooperative patients with bleeding disorders, I had another most suitable subject, a young woman on whom I had made the diagnosis of thrombopathic thrombocytopenia in 1961 on the basis of a platelet count of 156,000 with a prothrombin consumption time of 13 seconds corrected to 42 seconds with added hemolysate. After several years, I found she also had telangiectasia and an intolerance to aspirin. My most recent study of her had been in July 1971 when the platelet count was 160,000, the prothrombin consumption time 14 seconds, and the bleeding time over 20 minutes. When I studied her again on Feb. 11, 1972, the findings were essentially the same, except that the bleeding time was 12 minutes. After one week of therapy, which consisted in a high dietary intake of the soybean principle, the results were even more striking than in the first patient (Fig 8). The bleeding time had become entirely normal and the clotting factor in the platelets was brought into the normal range (Fig 9).

In addition to these two cases, two boys with the same combination of hereditary telangiectasia and thrombopathic thrombocytopenia are now being studied and the same type of results obtained. Interestingly, a third brother has telangiectasia but no platelet defect. He is entirely normal clinically. This makes it seem likely that the telangiectasia and the thrombopathy are genetically independent of each other but, clinically, the defect of one accentuates the other.

These results clearly demonstrate that the clotting factor in the platelets is similar or identical to a

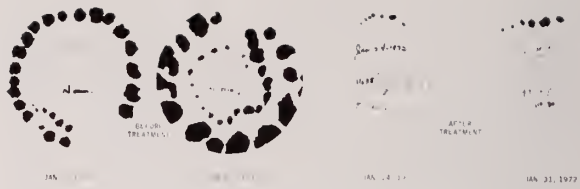

Figure 8—Bleeding time (Duke) in a case of hereditary thrombopathic thrombocytopenia with telangiectasia, before and after treatment with soybean phospholipids.

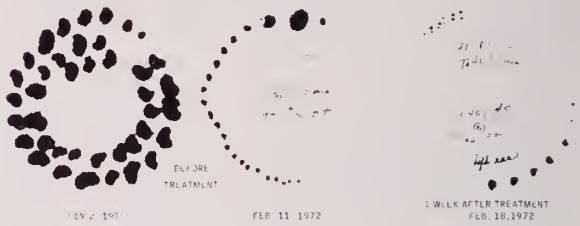

Figure 9—Bleeding time (Duke) in case of hereditary thrombopathic thrombocytopenia and telangiectasia, before and after treatment with soybean phospholipids.

factor present in an extract from soybeans, as shown by test tube experiments. Furthermore, the body appears to utilize this dietary accessory to restore normal platelets in place of defective platelets lacking the specific clotting factor. Whether the human organism can synthesize this specific platelet factor that is needed in the thromboplastin generation is not completely answered but it appears unlikely, thus giving the soybean factor true vitamin status. The exact nature of this factor is unknown although it seems closely associated with phospholipids. The assay method using the prothrombin consumption test and human plasma depleted of platelets as the assay medium should soon furnish the answer.

It seems likely that a deficiency of this newly postulated vitamin is rare because of its wide distribution in foods, but soybeans happen to have a particularly high concentration. An obvious deficiency of this possible vitamin becomes manifest only in such cases as are here reported. It does appear to be an essential part of the platelets but also of tissue thromboplastin which, too, has a ubiquitous distribution in the body. It has long been known that human milk has a high concentration and one might well speculate whether this could be of nutritional significance.

The most striking result obtained in this study has been the spectacular correction of the bleeding time in patients having hereditary thrombopathic thrombocytopenia combined with telangiectasia by employing a high oral intake of the soybean principle. The

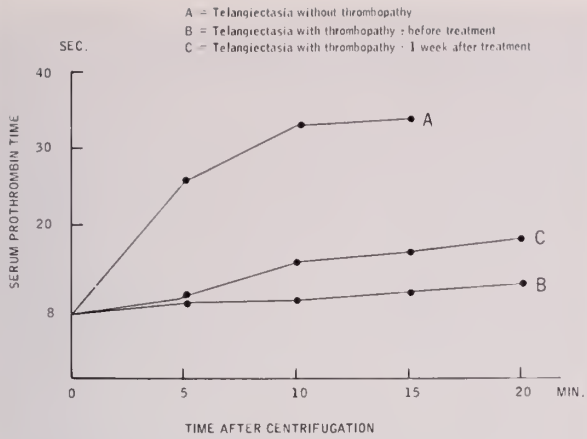

Figure 10—Prothrombin consumption time in a patient with hereditary thrombopathic thrombocytopenia and telangiectasia, before and after treatment for one week with soybean phospholipids. In telangiectasia without defective platelets, the test is normal (A).

mechanism of this correction is not understood. Whether it consists in correcting defective platelets is still to be determined. It should be remembered, however, that both the bleeding time and the tourniquet test are often exceedingly abnormal in telangiectasia without any demonstrable platelet dysfunction.

Summary

Two established vitamins, C and K, have as their basic function the maintenance and repair of body tissue. Deficiency of either impairs the maintenance of body tissue that may lead to spontaneous hemorrhage. The results reported in this study strongly suggest that a third vitamin is essential in hemostasis. It is abundantly present in the phospholipid fraction of soybeans. It is postulated that this vitamin supplies the specific factor found in normal platelets and in tissue thromboplastin. The wide distribution of tissue thromboplastin in the body is best explained by the assumption that it, with a co-factor—factor VII, are operative in tissue maintenance and repair. Since factor VII requires vitamin K for its synthesis and tissue thromboplastin derives its basic component from the principle abundantly present in the phospholipid fraction of soybeans, the answer is suggested as to how vitamin K and the newly proposed vitamin function jointly in the maintenance and repair of body tissue and thus supply a new facet of hemostasis.

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Cytotoxic Drugs in Treatment of Nonmalignant Diseases

A limited number of reprints of the proceedings of a Combined Clinical Staff Conference at the National Institutes of Health, published in the April 1972 issue of *Annals of Internal Medicine*, are now available to interested physicians on request.

CYTOTOXIC DRUGS IN TREATMENT OF NONMALIGNANT DISEASES (76:619–642, 1972)

Studies presented in this conference point out that the basis for using cytotoxic drugs in inflammatory diseases of uncertain cause is their immunosuppressive properties. These drugs interrupt nucleic acid and protein synthesis, thereby inhibiting various immune responses at different stages. Specific inhibition of an immune response is possible through drug-induced tolerance. Many of the agents have anti-inflammatory properties that may be a major factor in their efficacy.

In short-term controlled trials, both cyclophosphamide and azathioprine have been useful in treatment of rheumatoid arthritis and systemic lupus erythematosus, cyclophosphamide in nephrosis, and methotrexate and azathioprine in psoriasis and psoriatic arthritis. Azathioprine was ineffective in iridocyclitis, nephritis, nephrosis, Crohn's disease, chronic hepatitis, and asthma.

Cytotoxic drugs may increase the risk of infection, predispose to malignancy, and increase mutations in offspring. Specific side effects include hemorrhagic cystitis from cyclophosphamide, cirrhosis from methotrexate, and altered germ cell production by alkylating agents. Only long-term controlled trials, not uncontrolled reports or positive short-term controlled trials, will justify widespread clinical use of these drugs in inflammatory diseases.—INFORMATIONAL OFFICER, The Clinical Center, Rm. 1N–248, National Institutes of Health, Bethesda, MD. 20014

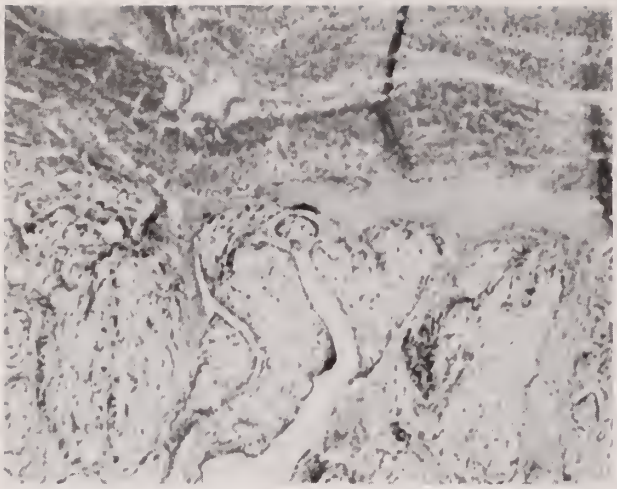

Figure 1—Wall of the hemorrhagic ruptured tract is characterized by hemorrhage above and lining placental elements below. Abortive villous structures with cytotrophoblastic and syntrophoblastic decidual elements are present.

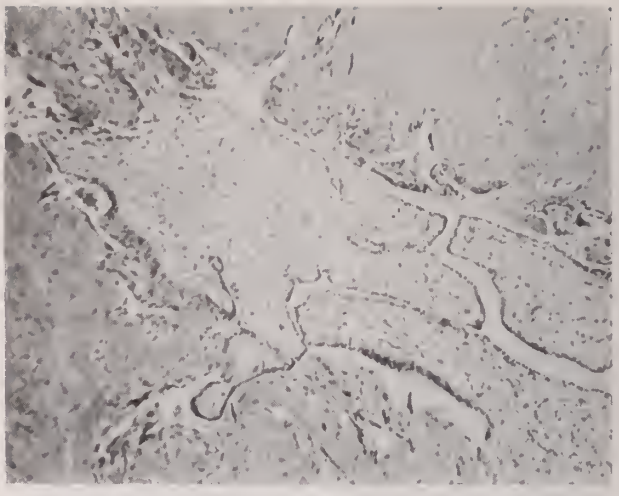

Figure 2—Deep extension of decidual elements into the underlying myometrium is illustrated.

Spontaneous Rupture of the Uterus at Twelve Weeks Gestation

CASE REPORT

WARREN N. OTTERSON, Colonel, MC
STUART D. WILSON, Lieutenant Colonel, MC
Fort Sam Houston, Texas (San Antonio)

SPONTANEOUS RUPTURE of the gravid uterus prior to the onset of labor is extremely uncommon. This is especially true when cases in which prior surgery had been performed are excluded. Felmus, et al[1] in a complete review were able to find only 116 cases and added five of their own. Two additional cases have been reported in recent publications.[2, 3]

Case Report

A 37-year-old Okinawan, gravida VI, para O, had been followed in the prenatal clinic at 2-week intervals with a last menstrual period of June 18, 1969. She was given 250 mg of hydroxyprogesterone (Delalutin®) intramuscularly at each visit.

She admitted to two induced abortions at approximately 8 weeks gestation and two spontaneous early abortions followed by dilatation and curettage on each occasion. There was a possibility of a hysterotomy at age 21 via a 5-cm transverse suprapubic incision when she was approximately 16 weeks pregnant. She had been made aware of uterine myomata being present for about four years.

On Sept. 16, 1969, she was admitted to the U. S. Army Medical Center Hospital, Ryukyu Islands, with a history of 16 hours sudden lower abdominal pain without syncope, nausea, or vomiting.

Physical examination on admission revealed diffuse abdominal tenderness with rebound tenderness. The vital signs were stable. A culdocentesis yielded nonclotting blood. A pelvic examination one week prior to admission had revealed the uterus as irregular, soft, and of 12 to 14 weeks gestational size.

At celiotomy, soon after admission, 1500 ml of fresh and old blood were found in the peritoneal

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Doctor Wilson was Chief of Pathology, U. S. Army Hospital, Ryukyu Islands.

Reprint requests to: Medical Library, Brooke General Hospital, Fort Sam Houston, Tex. 78234.

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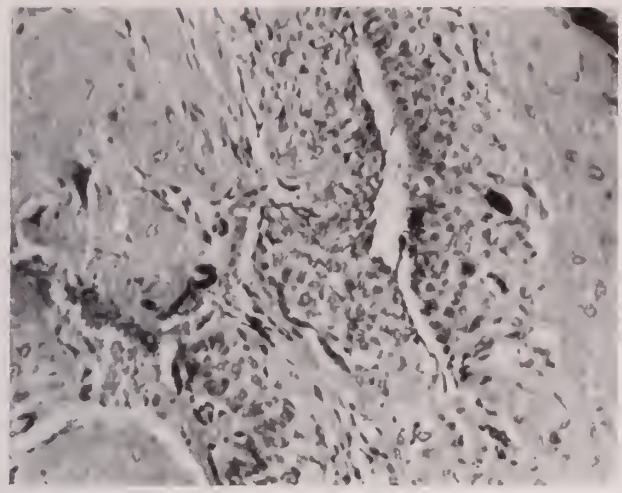

Figure 3—Deep extension of cytotrophoblastic and syntrophoblastic elements into the myometrium underlying the hemorrhagic tract.

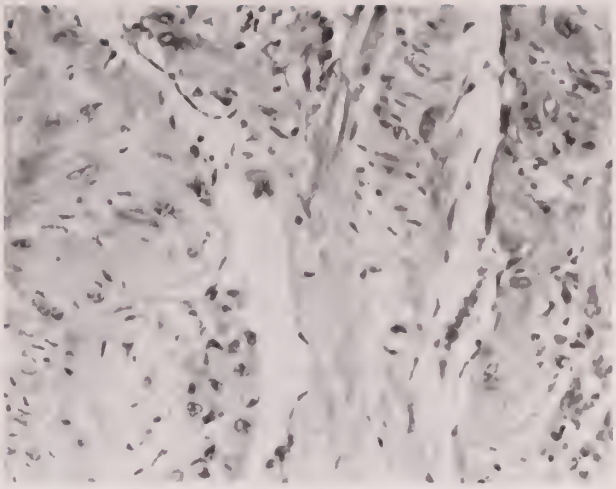

Figure 4—Sinus vascular channels with cytotrophoblastic elements in an intravascular position were occasionally encountered deep in the myometrium, adjacent to the perforation tract.

cavity with fragments of placental tissue. The adnexae were normal. The uterus was about 14 weeks gestational size with multiple myomata. A 1-cm perforation with active bleeding was noted in the right posterior fundal area surrounded by placental tissue at the site. A gross diagnosis of placenta percreta was made.

A total abdominal hysterectomy was performed after hysterotomy and evacuation of the uterine contents. Two thousand milliliters of whole blood were replaced. Pathologic studies confirmed the suspected placenta percreta. The postoperative course was uneventful.

Discussion

Rupture of the pregnant uterus is a life threatening complication to the mother and fetus with maternal mortality generally stated to be 3% to 5% and fetal mortality up to 75%. The excellent review of Felmus, et al[1] covers the classification of types of uterine rupture and discusses etiologic factors in spontaneous rupture prior to labor and without previous uterine surgery. One or more of the following features usually are present in an analysis of the patient's history or a review of the tissue removed at the time of surgery:

(a) Previous curettage (with or without uterine perforation) or manual removal of the placenta.[1, 2]

(b) Previous endometritis and myometritis such as after septic abortion, puerperal infection, or amnionitis.[1]

(c) Adenomyosis.[1]

It is interesting to note in the review of Felmus, et al[1] that one-fourth of the patients had had previous instrumentation, one-third ruptured prior to the sixth month of gestation, and three cases were preceded by trophoblastic disease.

There are two case reports of repeated rupture after closure of a simple tear.[4, 5]

Placenta accreta has been a significant pathologic finding with or without previous uterine surgery.[3, 6]

Summary

A case of spontaneous rupture in the posterior fundus of the gravid uterus of 12 weeks gestation is presented. The early gestation in this case is felt to be exceptionally unusual. A detailed history presented numerous clues to the diagnosis, i.e., repeated dilatation and curettage for spontaneous abortions and induced abortions. The finding of placenta percreta is not unusual in a case such as this.

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Editorial Comment

Colonel Warren N. Otterson's very interesting case report emphasizes the hazards of repetitive invasion of the uterus. The complication of infection can follow and can create an environment inviting catastrophe when subsequent pregnancy occurs. Repetitive instances of traumas and metritis which can follow any uterine curettage can be the basis of repeat spontaneous abortions, the incompetent cervix, ectopic pregnancy, as well as the ruptured uterus.—F. J. HOFMEISTER, MD, Milwaukee, Wisconsin

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available from the Charitable, Educational and Scientific Foundation

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Here is a list of student loan funds designed to aid Wisconsin students in medicine, dentistry, nursing, pharmacy and allied medical fields. These loan funds have been donated by individual physicians, county medical societies, personal memorials, and from other sources. In some instances, the CES Foundation acts as administrator of loan funds for other organizations or institutions.

These long term, low interest loans usually are limited to $500 per semester for a total of three years and generally are granted only when other sources of aid are unavailable. No interest is charged until two years after graduation from the professional school in which the student was enrolled.

Your contributions to any of these or the start of new funds can help the Foundation serve more deserving young people. Your check should be made payable to the Charitable, Educational and Scientific Foundation, specifying the particular fund you are supporting.

The funds and their requirements are shown at the right.

Interested persons are urged to contact the Charitable, Educational and Scientific Foundation, Box 1109, Madison, Wisconsin 53701.

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Hemodialysis in the Home

One Year's Experience

WELDON D. SHELP, MD
Madison, Wisconsin

SINCE 1963, hemodialysis performed by the patient and his assistant in the home has proven to be a feasible approach to the treatment of patients with chronic renal failure who do not have a suitable living related kidney donor or who are not considered suitable renal transplant candidates.[1]

At present, five hospitals within the state of Wisconsin offer training programs in home dialysis.* The program at Methodist Hospital in Madison was established as part of the Comprehensive Renal Disease Program of the Wisconsin Regional Medical Program and opened in February 1971.

So as to better define the success of hemodialysis in the home within the state of Wisconsin, it seemed appropriate to summarize one year's experience with home dialysis training at Methodist Hospital, emphasizing the outcome of the patients and their degree of rehabilitation.

Methods

Selection of patients for home dialysis training was based on a synthesis of data related to psychosocial factors (emotional stability, basic intelligence, motivation, economic resources, suitability of the home), the availability of an assistant and the severity of physical disability (e.g. degree of extrarenal complications of diabetes mellitus). Age per se and the patient's premorbid educational and occupational background were not seriously considered.

Instructional Technique

Patient and assistant training consisted of two integrated phases, theoretical and practical. Theoretical training was carried out primarily by slide-tape lessons supervised by a nurse instructor. Areas considered included basic normal and abnormal renal physiology, dialysis theory, diet, medications, sterile technique, and the like.

Practical training related to the performance of hemodialysis and was primarily "on the job" in nature, with demonstration-return demonstration being the principal technique.

Training progress was assessed by instructor evaluations and appropriate testing.

Home Evaluation and Patient Surveillance

Early in the training period, the nurse instructor performed a home visit, with emphasis on required physical alteration in plumbing and electrical outlets. Several water samples were analyzed for electrolyte content by the State Laboratory of Hygiene to assess water processing requirements.

In each instance an attempt was made to establish liaison with the referring physician and county or visiting nurses, so as to provide local medical support when the patient returned home. In most cases such liaison was successful with good cooperation from local medical authorities.

Each home patient and his partner have been seen at monthly intervals at Methodist Hospital, at which time physical and biochemical status are evaluated. Both patients and partners participate in group discussions with a psychiatrist or social worker, which results in a sharing of the various problems encountered with home dialysis.

At about three-month intervals, the nurse coordinator and social worker carry out home visits to assess the degree of adjustment to dialysis by the family and the continuation of dialysis competence.

Results

From Feb. 1, 1971 through Jan. 31, 1972, a total of 30 patients were evaluated as possible home dialysis training candidates. Of this number 14, or 47%, were selected for training. One of the patients received a successful renal transplant prior to completion of training.

Data relating to the subjects who completed home training are outlined in Table 1. The average patient age was 40 years, with a slight preponderance of males. The most common basic renal disease was chronic glomerulonephritis (7 cases). Two patients had diabetic nephropathy and one each had familial nephritis, polycystic disease, obstructive uropathy, and malignant nephrosclerosis.

The patients live in widely scattered areas of the state, and with one exception (Madison) chronic hemodialysis facilities are not available in their home communities.

The period of training for patient and assistant varied considerably, as would be expected. The stated training period included weekends which ordinarily were not utilized for training. In addition, a

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few patients with extended training periods were delayed because of logistical problems with home machine delivery.

Table 2 summarizes clinical and laboratory data of patients currently receiving home dialysis. Except for patients 7 and 8, no significant problem with hypertension has been encountered, and only patient 7 requires antihypertensive medication.

The mean hematocrit for the group is 21.1%, which is appropriate for this patient population. Except for patient 10, who is not a transplant candidate, the group has not received transfusions since arriving home. Patients receiving chronic hemodialysis adapt remarkably well to stable anemia, as is exemplified in this group by their degree of work tolerance and rehabilitation rate. All subjects are receiving oral iron and folic acid supplementation to minimize deficiency of these essential factors.

In an attempt to prevent development and/or progression of renal osteodystrophy and metastatic calcification in these patients, it is desirable to maintain the serum phosphorus concentration at less than 6 mg/100 ml with a combination of dialysis and vigorous antacid administration.[2] Six of the nine patients with a current serum phosphorus determination have achieved this goal.

Peripheral and autonomic neuropathy as documented by electromyography is considered an objective component of the uremic syndrome.[3] The initiation and frequency of dialytic therapy are frequently determined by the presence and magnitude of neuropathy. The majority of patients (Table 2) manifested some degree of neuropathy when dialysis was started and all have improved except patient 12, who has diabetic neuropathy. Electromyographic data initially ranged from normal to significantly prolonged conduction times, but on serial three-month repeat studies, all have improved or remain stable.

The definition of rehabilitation has many variations. It is here meant return to gainful employment, which of course, includes the duties of a homemaker. By this definition, Table 2 indicates that 80% of the home patients have been rehabilitated.

Discussion

During the past decade, the treatment of patients with irreversible chronic renal disease has dramatically changed with the widespread application of hemodialysis and renal transplantation. Current national figures (January 1972) state that 4,857 patients are receiving hemodialysis, approximately 40% of these at home.[4]

There is little doubt that in terms of current therapeutic success, renal transplantation using a living related donor, preferably a sibling, is the method of choice. Unfortunately, it is estimated that only about 25% of the patients have such an eligible donor. Based on national estimates, each year between 100 and 150 renal patients living in Wisconsin will progress to the point where they are medically suitable for definitive therapy. Assuming that 25 to 30 of these will receive a successful living donor transplant, approximately 100 patients annually remain who will require long-term hemodialysis, either for life or until a suitable non-related, recently deceased donor becomes available.

It is readily apparent that over a period of a few months and years, if all eligible patients are accepted

TABLE 1—*Data from patients who completed the home dialysis training program from February 1971 through January 1972*

Patient	Age	Sex	Wisconsin Home	Dialysis Assistant	Inclusive Training Period (days)
1	28	M	Menomonie	W	54
2	52	M	Monroe	W	23
3*	51	M	Monona	W	68
4†	32	F	Madison	H	73
5	45	F	Edgerton	H	63
6‡	40	F	Ashland	S	84
7	44	M	Arena	W	48
8	27	M	Plover	W	51
9	17	M	Watertown	Mo	78
10	68	F	Fond du Lac	H	63
11	34	M	Wisconsin Rapids	W	101
12	42	M	Janesville	Mo	139
13	42	F	Watertown	H	141

M—Male W—Wife S—Sister
F—Female H—Husband Mo—Mother
*Died following renal transplantation after 24 weeks of home dialysis.
†Received successful renal transplant after 8 weeks of home dialysis.
‡Died 11 weeks after starting home dialysis.

TABLE 2—*Clinical data of patients who completed training and are performing home dialysis as of February 1972*

Patient	Time at Home (Weeks)	BP (mm Hg)	Hct (%)	Predialysis Phosphorus (mg 100 ml)	Clinical Neuropathy	Rehab
1	36	130/80	25	5.0	no	yes
2	36	160/90	19	4.8	no	yes
5	32	110/50	21	3.3	no	yes
7	27	190/90	17	5.0	no	yes
8	22	170/90	21	8.9	no	yes
9	7	110/70	29	10.7	no	yes
10	10	170/84	22	4.4	no	yes
11	6	140/80	17	—	no	no
12	3	130/80	23	7.9	yes*	no
13	1	140/80	17	4.4	no	yes
Mean	18	145/79	21.1	6.0		

Rehab—Rehabilitation
BP—Blood Pressure
Hct—Hematocrit
*—Patient has diabetic neuropathy

for treatment, existing dialysis facilities within the state would become saturated with patients, even when assuming attrition related to death or successful transplantation.

A second major problem related to hemodialysis within a medical facility, which was recognized soon after chronic dialysis began, concerned the significant expense of such therapy. Although total costs vary, the figure quoted currently is between $25,000 and $30,000 per patient per year. It required little reflection to realize that from the economic aspect alone, one or more alternative approaches had to be established.

The concept of home dialysis was thus conceived and applied in 1963.[5] Results to date have been most gratifying and strongly suggest that virtually all capable patients should be considered for such therapy.[1]

The experience of Methodist Hospital must be considered preliminary because of the small number of subjects involved, and the abbreviated interval of home dialyses performed. However, some tentative conclusions can be reached.

First, manifestations of chronic renal failure and complications thereof, such as hypertension, can be controlled at least as well in home patient when compared to those treated in a hospital. Home patients can readily tailor their treatment frequency and interval to suit their needs and are not restricted to a regimented hospital schedule. Dietary protein is virtually unrestricted in this group, although discretion in fluid, salt, and potassium intake must be applied.

A second advantage, expressed by all of our patients, is their preference for home dialysis over hospital dialysis. This phenomenon becomes apparent after a few weeks of adjustment at home. As a corollary, both the patient and family appear to maintain a higher degree of emotional stability if treated at home. Patient independence is fostered and the problem of role-reversal, particularly with male patients, is minimized or abolished. A significant aspect of hospital dialysis, which often is ignored, concerns the time and expense of travel to and from the unit. Home dialysis virtually eliminates this problem.

Any therapeutic program designed to prolong life must consider the quality of this sustained life. Certainly a return to gainful employment or resumption of homemaking activities contribute significantly to this quality. It is clear from our results, and those of others[1] that a majority of patients performing home dialysis can achieve this goal.

Finally, hemodialysis in the home significantly reduces patient costs. Although figures from our group of patients are incomplete, annual expenses for home dialysis would appear to approximate $7,000 per patient, or a reduction of 70% to 75% when compared to hospital treatment.

Thus, through appropriate utilization of existing training facilities it would appear that a majority of eligible patients in Wisconsin are now afforded the opportunity to learn and apply the most acceptable and least costly method of long-term hemodialysis—dialysis in the home.

Summary

Experience at Methodist Hospital, Madison, Wisconsin, in the training of patients and family members for performing hemodialysis at home is reviewed over a one-year period. Results support those of others in concluding that home dialysis is the most feasible alternative for a significant number of patients who require maintenance dialysis for survival. Advantages include patient acceptance, individualized treatment schedules, improved rehabilitation rate, and markedly reduced cost. With proper utilization of existing training facilities in Wisconsin, most qualified patients should be able to perform dialysis at home.

ACKNOWLEDGMENT: The continued support of the Wisconsin Regional Medical Program, John S. Hirschboeck, MD, Coordinator, is greatly appreciated. The author also appreciates the dedicated efforts of the Methodist Dialysis Unit staff.

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Multiple Primary Melanoma Following Administration of Levodopa

J L SKIBBA, MD, J PINCKLEY, MD, E F GILBERT, MD and R O JOHNSON, MD, University of Wisconsin Medical Center, Madison, Wis:

Arch Pathol 93:556–561, 1972.

The case of a Parkinson patient who developed local recurrence of a melanoma four years after primary excision and four months after initiation of L-3,4-dihydroxyphenylalanine (L-Dopa) therapy is described. This patient also developed multiple pigmented skin lesions. Light microscopic study of three excised lesions showed typical primary melanomas. The possible relationship between exacerbation of this patient's disease and the chronic oral administration of L-Dopa is discussed. □

Vasectomies Triple in One Year

The number of vasectomies performed by doctors in their offices during 1970 zoomed to 700,000—more than triple the number done the year before, according to the National Disease and Therapeutic Index. □

Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Heparin Therapy

DONALD R. KORST, MD
PETER C. RAICH, MD
Madison, Wisconsin

HEPARIN, A HIGH MOLECULAR weight biologic product with anticoagulant activity, has been investigated in the laboratory since early in this century. In studies to determine the thromboplastic substance of the body a fraction of liver, heart and brain with anticoagulant properties was noted by McLain and Howells. The purified antithrombin substance was first reported in 1916 and given to humans in 1935 by Best. It is a mucopolysaccharide of alternating sequence of uronic acid and hexosamine in a highly sulfated molecule with a strong anionic charge.[1] (Figure 1)

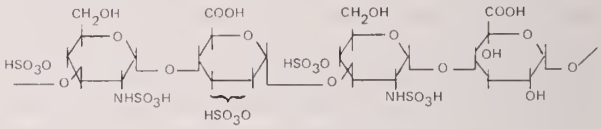

Figure 1—Heparin

Action of Heparin

Heparin appears to have three types of biologic activity. Its *primary* activity is that of inhibiting or neutralizing several of the circulating coagulation factors. It has a specific antithrombin effect as well as a secondary effect on Factor IX in the stage of prothrombin activation. There may be some additional direct effect on platelets. The heparin molecule may be neutralized or inactivated partially by absorption with protamine, another heavy protein molecule, which thus prevents heparin from exerting its full effect on the coagulation factors. A *second* activity of heparin is its specific effect in releasing lipoprotein lipase resulting in lipid clearing. This occurs at a much lower dose than would affect the coagulation mechanism as reflected by the usual clotting tests.

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This lipid clearing effect also may be of longer duration than the anticoagulant effect.

A *third* biologic action of heparin involves the inhibition of the cryofibrinogen reaction in those abnormal conditions of hypercoagulation associated with malignancy and other disorders. More speculative biologic properties of heparin are that it may antagonize histamine releasing substances or serotonin and may be part of the body's natural defense against allergy and anaphylaxis. It also binds tightly with basic proteins and enzymes.[2,3]

Heparin is found in all tissues but in highest concentration in heart, skeletal muscle, and intestine. It is normally quite low in plasma. Total human body heparin is estimated at 20,000 units. It is thought to be released from the mast cells, along with histamine, particularly from those mast cells located in the perivascular space. Its commercial sources are porcine and bovine intestine, lung, and liver.

Indications and Contraindications for Heparin

The clinical uses of heparin are listed in Table 1. Generally, heparin is the agent of choice in acute life-threatening situations requiring anticoagulation. Because of its rapid onset of action it is frequently used for several days to one week in patients who are being prepared for long-term anticoagulation with oral agents. The contraindications to heparin therapy are outlined in Table 2. These include known bleeding from the gastrointestinal, respiratory or genitourinary tract, ulcerative colitis, blood dyscrasias, subacute bacterial endocarditis, dissecting aneurysms, and surgery of the central nervous system or the eye. Relative contraindications are lack of satisfactory laboratory control, severe hypertension, surgical procedures within 24 hours, polycythemia vera, and a past history of cerebral hemorrhage.

Toxicity of Heparin

Toxicity due to heparin consists mostly of bleeding at local sites of injury in patients receiving very large doses (Table 3). Some allergic reactions are known; however, these are very rare. Chronic administration of heparin may result in dysesthesia pedis, alopecia, impotence, and osteoporosis.

Bleeding of severe nature during heparin therapy may occur in one to two percent of patients. However, some degree of bleeding complications is recorded in as high as 20 percent of patients on heparin therapy. Bleeding complications are more apt to occur in older female patients. The most serious of these is cerebrovascular bleeding. Other serious complications are retroperitoneal hemorrhage and bleeding into the adrenal gland, leading to adrenal cortical insufficiency. The occurrence of gastrointestinal bleeding while on heparin therapy suggests the presence of an undetected latent lesion in the gastrointestinal tract. Other complications are pulmonary hemorrhage, hematuria, hematoma formation, ecchymoses, and epistaxis.

Route of Administration and Dosage of Heparin

Heparin activity is standardized by the use of coagulation tests. A unit of heparin which has a predictable amount of anticoagulant activity by the recalcification plasma clotting time is the standard used by pharmaceutical companies. Between 130 to 170 units of heparin may equal one milligram of dry material. Thus, it is important that therapeutic dosage be designated in units of heparin, since the milligram dose may vary from preparation to preparation.

Heparin must be given by injection because there is no effective absorption through the gastrointestinal tract. The most effective and most commonly used route is intravenous. When given subcutaneously there is a 15 to 30 minute lag of activity, a relatively low maximum level of heparin activity, and an increased duration of action. Intramuscular heparin results in local irritation and unpredictable response. Continuous drip intravenous heparin therapy may provide adequate levels of anticoagulation; however, the intermittent intravenous administration of heparin is most commonly employed. Metabolism of heparin is rapid and occurs probably by desulfation in the reticuloendothelial system and in the liver,

TABLE 1—*Clinical indications for heparin therapy during the acute phase of the disease*

Pulmonary embolism
Acute thrombophlebitis (venous thromboembolism)
Acute myocardial infarction (selected cases)
Shock and cardiac arrest
Cavernous and lateral sinus thrombosis
Recurrent cerebral embolism
Retinal venous occlusion
Vascular and cardiac surgery
Hemodialysis
Prolonged administration of intravenous fluids
Diffuse intravascular coagulation
Special cardiac conditions during pregnancy

TABLE 2—*Contraindications to heparin therapy*

Blood dyscrasia with hemorrhagic diathesis including polycythemia vera
Bleeding lesions in gastrointestinal, respiratory, or genitourinary system
Ulcerative colitis
Surgery of the central nervous system or eye
Severe hypertension particularly in older patients
Subacute bacterial endocarditis
Dissecting aneurysm of aorta

TABLE 3—*Hemorrhagic manifestations due to heparin therapy*

Major—May Cause Death	
Central nervous system	
Gastrointestinal with bowel obstruction	
Retroperitoneal—pericardial	
Renal with obstructive uropathy	
Minor	
Ocular	Epistaxis
Hematuria	Bleeding gums
Ecchymosis and hematomas	Hemoptysis

which results in rapid clearing of heparin following intravenous administration. The half-time clearance of heparin measured by radioactive and coagulation techniques indicates that heparin is half cleared from the circulation in 90 to 100 minutes following an intravenous dose.

Therapeutic dosage requirements have not been firmly established. In general, 6,000 to 8,000 units of heparin given intravenously every four hours during the first 24 hours to 48 hours in patients with acute pulmonary embolism will not only effectively arrest clot formations and propagation but also relieve the associated pulmonary vasoconstriction and bronchospasm thought to be triggered by release of amines especially 5-hydroxy-tryptamine from platelets in the fresh embolus. After this initial period of therapy the dosage of heparin is reduced somewhat and maintained at a level that will cause a change of less than two times the baseline value of the clotting time determined just prior to the next dose of heparin. In addition to the Lee–White whole blood clotting time, the anticoagulant effect of heparin may be followed also by the activated clotting time of whole blood and by the partial thromboplastin time of plasma. Doses of more than 4,000 to 6,000 units every four hours are occasionally necessary for adequate anticoagulation effect. Heparin therapy is usually continued for a period of 6 to 10 days which is the time required for the thrombus to become thoroughly adherent to the vessel wall. If the patient is to be converted to oral anticoagulant therapy, an overlap of about 5 days should be allowed due to the slow onset of action of the coumarin agents. One must keep in mind that the one-stage prothrombin time may be slightly prolonged by the heparin.

What the physician must keep in mind is that the clearance of heparin following a given intravenous dose is usually quite rapid, and it should be anticipated that by the end of three to four hours there will be very little heparin left in the circulation and therefore the clotting test may be near normal at this time. However, 30 to 60 minutes following the next intravenous dose there will be a full anticoagulant effect. Therefore it is probably the best clinical practice to select a reasonable dose for the patient, such as 5,000 units given intravenously every four hours, and monitor the coagulation time once a day in a reliable laboratory from a specimen drawn three to four hours after the intravenous injection of the heparin in order that one may be sure that there is not an excessive anticoagulant effect. Repeated venipunctures can be avoided by the use of the pediatric scalp vein infusion set with a 21 or 23 gauge needle inserted into one of the forearm veins and securely taped in place. The rubber cap which seals the end of the set's plastic tubing is easily penetrated with a needle, and heparin may be administered easily by direct displacement.

Summary

Heparin is a useful anticoagulant and is the only one available that has an immediate onset of action. It must be monitored closely by the physician and the laboratory, the patient usually being in the hospital. A thorough knowledge of the pharmacology and metabolism of the drug is necessary to avoid major bleeding complications. The physician cannot depend entirely on the laboratory in monitoring the administration of heparin but must adjust the dose of the drug in a judicious manner depending on the clinical situation. The rapid antithrombin activity of heparin makes it the drug of choice in treating patients with active or acute thrombus formation with or without embolization.

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List of Approved Hospital Cancer Programs Released

To help hospitals establish and maintain cancer follow-up activities, the Commission on Cancer of the American College of Surgeons periodically surveys hospital cancer programs, and grants approval to those which meet certain basic standards.

A current list of 840 programs approved as of Jan. 1, appeared in full in the April 1972 issue of the *Bulletin* of the American College of Surgeons.

The cancer programs published in the *Bulletin* have been surveyed at the request of their administrators and/or medical staffs. The approval status is based on the level of excellence in relation to the established standards for approval stated in the College's *Manual for Cancer Programs*.

The College conducts this project under grant and contract support from the American Cancer Society and the Division of Regional Medical Programs of HEW.

The College's *Manual*, published in 1966, describes in detail the requirements of the American College of Surgeons for the approval for cancer programs. The *Manual* may be obtained, free of charge, from the Department of Professional Activities, Cancer, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611. Copies of the April issue of the *Bulletin* containing the approved list are also available. □

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Lymphographic Tumor Evaluation

GEORGE W. WIRTANEN, MD
Madison, Wisconsin

LYMPHOGRAPHY IS THE radiographic examination of lymphatic vessels and nodes utilizing non-water soluable contrast medium injected directly into lymphatic vessels. It is the only method short of laparotomy and thoracotomy to macroscopically evaluate the lymph nodes along the axial skeleton; and, even then, these exploratory surgical procedures without lymphography allow only for random nodal sampling. Film interpretation involves an evaluation of macroscopic nodal appearance and depends upon an accumulation of experience. False positive interpretations do occur which can be confirmed histologically, but microscopic nodal involvement is beyond the scope of the examination.[1] The resultant false negative interpretations will only become manifest lymphographically when the microscopic changes become macroscopic.

Our initial experience is similar to that of others in that small non-specific nodal changes were thought to be significant, resulting in a disproportionate and unacceptable rate of false positive examinations. This was followed by some skepticism, with resultant conservatism in interpretation and consequent false negative studies. Accumulated experience with histological confirmation has subsequently produced a useful clinical examination in the evaluation of tumor, which is the subject of this report.

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Paper presented at the 17th Annual Fall Cancer Conference, University of Wisconsin Medical Center, Oct. 16, 1971, Madison.

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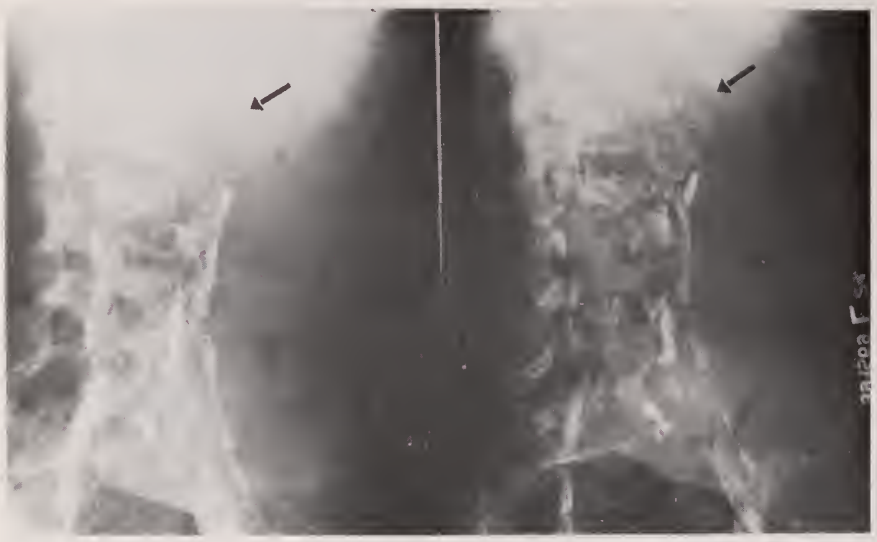

Figure 1—The vascular phase in a left posterior oblique projection demonstrates lymphatics displaced about a mass at the level of L-2 in the illustration on the left. The illustration on the right demonstrates opacification of the nodal mass which has the usual appearance of lymphomatous involvement. The remainder of the opacified periaortic and iliac nodes are radiographically normal in appearance, and these films demonstrate the value of directed surgical biopsy.

Historical

Servelle in 1945 performed lymphography with Thorotrast but the carcinogenic properties of this material resulted in discontinuance of the procedure. Oily contrast was first used by Bruun and Engeset in 1956. The use of Ethiodol®, 37% iodine in organic combination with the ethyl esters of the fatty acids of poppyseed oil, injected directly into the lymphatic vessels, was described by Procopec in 1959, Hreshchyshyn and Shechan in 1960, and Wallace in 1961.[2]

Figure 2—These films taken the day following lower extremity lymphography demonstrate opacification of left supraclavicular and left axillary nodes. The nodes do not appear to be involved by metastases.

Anatomic and Physiologic Considerations

The lymphatic system is an extensive network of vessels which collects lymph from various organs and tissues, lymph nodes which act like filters along the course of these vessels, lymphatic organs which resemble lymph nodes such as the tonsils and other aggregates of lymphatic nodules, and organs such as the spleen and the thymus.[3] It returns large molecular particles, especially proteins, to the blood vascular system. Lymphatic vessels accompany blood vessels, and the larger lymphatics have an internal layer of endothelial cells and a middle layer of smooth muscle and elastic fibers. They are supplied by nutrient blood vessels and nerves, contain valves, and lymph is propelled by contraction of vessel walls. Lymphatics enter nodes at their margins and lymph flows to the marginal sinus, just beneath the capsule, then to the cortical and medullary sinuses and into efferent lymphatics. Reticular fibers and cells fill the lymph nodes. Lymph is a slightly yellow watery fluid with a specific gravity of 1.015 resembling diluted blood plasma, and should be distinguished from extracellular fluid.

Technique

Lymphography may be performed on the dorsum of each foot, on the dorsum of the hand for visualization of axillary lymphatics, in the sub-mental or posterior auricular area for visualization of deep cervical lymph nodes, and in the spermatic cord for visualization of nodes along the testicular vessels. Patients require no preoperative medication, meals are not held and the procedure does not require hospitalization. We utilize direct sky blue for visualization of the lymphatic vessels, mixing 3 ml with 1 ml of lidocaine (Xylocaine®), and a small quantity of this material is injected intradermally in the first

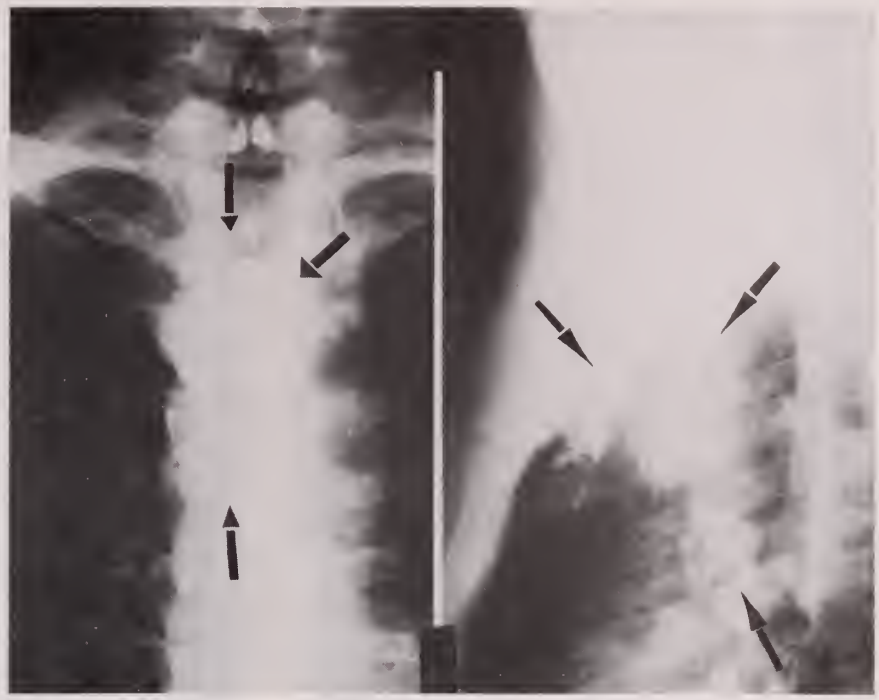

Figure 3 — Retrosternal nodes opacify with lower extremity lymphography in this patient with Hodgkin's disease. Opacification of these nodes is not constant, but they do occasionally opacify.

three interdigital spaces on the dorsum of each foot. Lymphatic vessels selectively transport the direct sky blue and become visible through the skin of the dorsum of the foot in 30 to 45 minutes. An incision approximately 2 cm long is made parallel to several lymphatics, following Xylocaine® locally, and a vessel is isolated and cannulated with a 30-gauge needle, utilizing a special clip without suture fixation.[4] The injection of Ethiodol® is done with a gravity injection apparatus,[5] a preliminary film is taken for contrast visualization to insure lymphatic fill, and film monitoring at regular intervals determines the total contrast quantity required. The procedure usually requires approximately 6 ml of contrast on each side to reach the level of the third lumbar interspace. Interrupted skin sutures and suitable dressings are applied to the incisions, and sutures are removed in 10 days.

TABLE 1—*Use of lymphography in the evaluation of patients with cancer*

1. The procedure provides for directed surgical biopsy for histological and bacteriological nodal examination of nodes which are most abnormal lymphographically.
2. Tumor patients are more completely staged with this procedure resulting in more effective treatment planning.
3. The radiotherapist may more selectively deliver radiation to tumor allowing for more effective normal tissue sparing.
4. The surgeon may evaluate his adenectomy during surgery.
5. The results of radiotherapy and/or chemotherapy may be objectively evaluated with serial film study.
6. Tumor activation, reactivation, or inactivity in opacified nodes may be evaluated for one to two years following the procedure.
7. The procedure allows for more complete evaluation of the patient with chyluria, chylothorax, and chyloperitoneum.

Films of the vascular phase of the lymphogram include anteroposterior and lateral dorsal spine films for visualization of the thoracic duct and cervical and axillary collaterals if they are opacified, and anteroposterior, lateral, and oblique films of the lumbar spine, and an anteroposterior film of the pelvis. These films are repeated the following day, and opacified inguinal, iliac, and periaortic nodes may be evaluated (Fig 1). Occasionally mediastinal, supraclavicular, cervical and axillary nodes may opacify (Figs 2 and 3).

Our personal experience includes lower extremity lymphography in over 1,000 patients. This technique, described for lower extremity lymphography, is technically similar to lymphography performed in the upper extremity, into a spermatic vessel, or in opacification of deep cervical nodes.

Indications

Lymphography may be utilized effectively in the evaluation of patients with cancer (Table 1). One of its more useful aspects is in directed biopsy of abnormal nodes. The lymphogram will demonstrate specific abnormal nodes and even occasionally suggest histological types,[6] so that radiologically pathologic nodes may be taken at the time of surgical exploration (Fig 4). Not only should histological examination of nodes be done but nodes should also be cultured for pathogens. Two of our patients with unsuspected tuberculosis had their disease process confirmed on nodal culture of abnormal appearing periaortic nodes. In addition to directed biopsy, it serves as a guide to complete adenectomy when serial films are taken in the operating suite during surgery.

The radiotherapist utilizes the opacified nodes to delineate the margins of tumor volume which is

Figure 4—A left posterior oblique projection is taken to evaluate the left periaortic nodes. The arrows designate nodes in which marginal nodal replacement has occurred in this patient with a malignancy of the left testicle, which was confirmed on subsequent surgical exploration.

Figure 5—Lymphography results in opacification of abnormal inguinal, iliac, and periaortic nodes in this patient with lymphosarcoma. The treatment field has been drawn on the patient and these field margins have been marked with lead solder for this confirmatory x-ray.

Figure 6—This 28-year-old patient had a laparotomy for this unresectable rhabdomyosarcoma. The illustration on the left demonstrates the lymphographic appearance of the tumor prior to therapy. The patient received intra-arterial actinomycin-D through percutaneously placed transbrachial artery catheters with selective infusion into both internal iliac arteries for 12 days. Concomitant radiation was delivered through opposing anterior and posterior ports and subsequent lateral boosts utilizing cobalt-60 teletherapy delivering 6000 rads tumor dose in 40 days. The film on the right was taken at the completion of therapy.

Figure 7—This patient with complete right periaortic lymphatic vascular fill, one week after the lymphogram, was found, on subequent surgical exploration, to have carcinoma of the head of the pancreas with regional nodal metastases. Lymphatic obstruction manifests itself by persistent lymphatic vascular fill. The lymphatics are usually empty within six hours after the completion of the procedure.

Figure 8—A lymphatico-venous shunt is present in the pelvis with opacification of an internal iliac vein (arrow) medial to a pelvic mass. These lymphatic venous anastomoses are present throughout the body and become physiologically functional in pathological processes such as obstruction.

under treatment (Fig 5). Serial films during the course of radiation will also demonstrate a decrease in tumor volume so that treatment portals may be adjusted to reduce radiation to normal tissues (Fig 6).

The contrast material remains in lymph nodes for periods of time longer than two years, and in most patients nodes may be adequately evaluated up to one year following the initial lymphographic study. Serial films are taken at the time of outpatient visits, and on the basis of film study one may determine whether nodes previously treated have responded to radiation or chemotherapy, or if normal nodes have become involved with primary or secondary lymph node tumor.

The vascular phase of the procedure may demonstrate the site of lymphatic obstruction (Fig 7) and its resultant lymphatic collateralization, lymphatic venous shunting (Fig 8), chylous ascites, chylothorax or chyluria.

The procedure is contraindicated in patients who exhibit iodine sensitivity and in those who have had previous lung irradiation. It is not contraindicated in patients with previous mediastinal irradiation. Fever without cough, and fever with cough are the two most frequent complications and occur in less than 5% of our patients. The oily contrast embolizes by way of the thoracic duct and subclavian vein to the capillaries at the alveolar level and is responsible for these symptoms. However, with adequate film monitoring during the procedure, overloading with contrast should not occur and these symptoms should not be present. Wound infection may occur on the dorsum of the foot; and in other large series the incidence is low, reportedly occurring in approximately 1% of patients.[7]

Summary

Lymphography is a radiographic procedure with little morbidity which allows for radiographic visualization of opacified nodes for extended periods of time, adding another dimension to the evaluation of the patient with cancer.

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Ectopic Pregnancy, Diagnosis Made Difficult by Presence of Intrauterine Device

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THE ACCURATE AND EARLY diagnosis of ectopic pregnancy is important today in minimizing maternal morbidity and mortality. Any contraceptive element of a mechanical nature, such as the intrauterine device, can and will continue to mask the early diagnosis of ectopic pregnancy; and the known side effects of the intrauterine device, such as intermittent pelvic pain and bleeding, can confuse the problem further.

The following two cases are being presented to make one more aware of the diagnosis of ectopic pregnancy and the potential problem that can arise which possibly could be circumvented.

Case One is that of a 26-year-old, Caucasian woman gravida III, para III, who had delivered a third child uneventfully in October 1969. At the time of her six weeks postpartum examination an intrauterine device was inserted. Six weeks later the patient was seen for a coil check and the examination was normal. This patient did have various admissions to the Clinic because of upper and/or lower abdominal pain, but examinations were negative and the medications dispensed were minimal. The patient's history was not remarkable, except that she did have a pelvic laparotomy at age 6, because of abdominal pain with an appendectomy being performed, but as stated by the patient, the pain pattern did not change and the appendectomy did not help her pelvic complaint.

The patient was seen on December 7, 1970. Her periods were regular and her last period had been on Nov. 21, 1970. There was no excessive bleeding and the intrauterine device was in place.

On Feb. 20, 1971, the patient was seen in the Emergency Room twice because of lower abdominal pain. The first time was early in the morning and the diagnosis of irritable intestine was made. She was advised to return to see her doctor in one week. She was seen again that evening because of increasing pelvic discomfort. She gave a history of regular menses except that she was having her periods every two weeks at this time and the last period had been on Feb. 15, 1971. The white blood cell count was elevated. She had a low-grade temperature and the gynecological examination revealed generalized pelvic discomfort with no other specific findings. The admitting diagnosis was that of pelvic inflammatory disease probably related to the intrauterine device. During this hospitalization the patient's intrauterine device was removed and she was treated with antibiotics. The patient was released on Feb. 23, 1971, to be followed on an out-patient basis. At the time of release she was afebrile and feeling well.

The patient was then seen at the office on Mar. 1, 1971, at which time she was spotting but again the examination was normal, and Delfen Foam® was prescribed as a means of contraception. The patient was seen again on Mar. 8, 1971, because of recurrent lower abdominal pain. There was tenderness in the left adnexa and posterior to the corpus. She was scheduled on an out-patient basis for a proctoscopic examination and barium enema, and was given laxatives to be taken at home. The patient was admitted via the Emergency Room on Mar. 16, 1971, following the use of the laxatives because of an increase in pain, weakness, and fainting spells. Examination revealed no inguinal adenopathy, abdominal masses or organomegaly, and there was no evidence of peritoneal irritation. The vagina was clean and somewhat congested. The cervix was hypertrophied, intact, and congested. The bimanual and rectovaginal examination revealed the uterus to be movable, mid-plane position, and could be moved to the anterior position with some mild tenderness. The rectovaginal examination revealed the uterosacral ligaments to be hypertrophied and extremely tender and nodular, especially at the peritoneal reflection. The diagnoses entertained were those of pelvic inflammatory disease and endometriosis. The patient was taken to surgery on Mar. 19, 1971, at which time a left salpingo-oophorectomy with a partial cystectomy on the right side was done. The patient's final diagnoses were: (1) ruptured fallopian tube, ectopic pregnancy; (2) ovary with

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follicular cyst; (3)corpus luteum cyst. The patient's postoperative course was quite uneventful. She was placed on oral contraceptives in the immediate postoperative period and then had another intrauterine device inserted on May 20, 1971. She has continued to have pelvic discomfort.

Case Two is that of a 32-year-old, Caucasian woman, gravida III, para III. She was seen on Aug. 19, 1966, for a routine gynecological examination, and an intrauterine device was inserted without incident. Her routine examinations from that time on were normal. The patient was seen on Feb. 15, 1971, with the chief complaint of a prolonged period. The patient's usual menstrual flow varied between 5 and 7 days every three weeks and not heavy. Her most recent period started on Feb. 1, 1971, and she was still flowing at the time of the examination. Her previous menstrual period had been the first week in January 1971. The abdominal and pelvic examinations were entirely within the range of normal. The cervix was clean and the intrauterine device was in place. The diagnosis was that of menometrorrhagia, etiology unknown; possibly endometrial or superficial myometrial ulceration secondary to the intrauterine device. The patient was given 250 mg of hydroxyprogesterone (Delalutin®) and 20 mg of estradiol (Delestrogen®) intramuscularly.

This patient continued to have some vague pelvic discomfort with intermittent spotting, and because of her symptoms the intrauterine device was removed on Feb. 28, 1971. The examinations, both bimanual and rectovaginal, were again within the range of normal. This patient continued to have pelvic pressure, constipation, and spotting with no withdrawal from the intramuscular medication.

She was then seen on Mar. 17, 1971, in the Emergency Room because of lower abdominal cramping of increasing severity, and stated that the pain was probably on the basis of constipation. Her examination at that time was suggestive of ectopic pregnancy so she was taken to surgery where the diagnosis of ectopic pregnancy was confirmed. A right salpingectomy was performed. The patient's postoperative course was entirely normal. On Apr. 16, 1971, the patient had an intrauterine device reinserted and to date has had no complications and her menstrual periods have been normal.

Comment

It is interesting to note that both patients wanted intrauterine devices reinserted. The complications of the intrauterine device are well documented regardless of their relative rarity. However, we believe that it is in the patient's best interest to suggest that some other modality—such as foam— be used in conjunction with the intrauterine device to at least minimize the complications related to pregnancy. We strongly recommend to all of our patients that the foam be used at least for the middle ten days of the menstrual cycle. □

Tricuspid Insufficiency: A Study of Hemodynamics and Pathogenesis

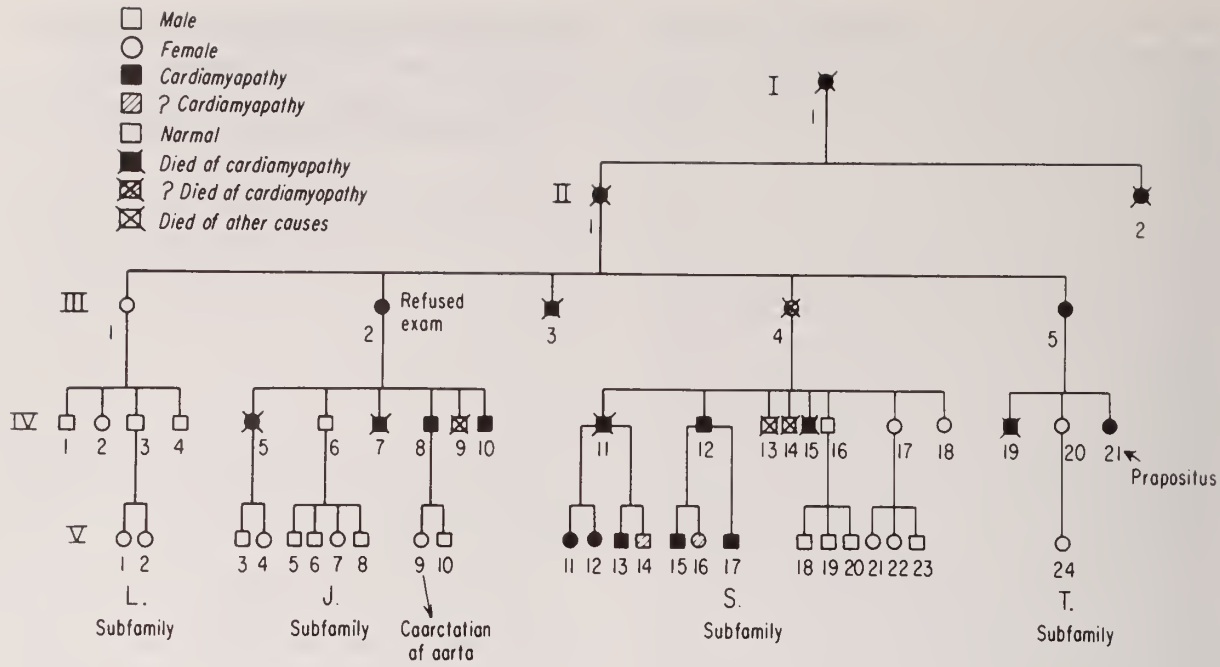
CHARLES E HANSING, MD and GEORGE G ROWE, MD, Madison, Wis: *Circulation* 45:793–799 (Apr) 1972

It has long been felt that the weak anatomic support structure of the tricuspid valve leads to frequent occurrence of tricuspid insufficiency in congestive heart failure. In addition to trauma, congenital, and rare causes of tricuspid insufficiency, rheumatic valvular disease may involve the tricuspid leaflets causing stenosis and insufficiency, usually in the presence of more severe aortic and mitral valve abnormalities. The clinical diagnosis of the presence and severity of tricuspid insufficiency is difficult and is complicated by the transient nature of this abnormality as well as its usual occurrence in subjects with other valve disease.

This paper presents correlative hemodynamic data from 100 consecutive catheterized patients with valvular heart disease in 90 of whom the presence of tricuspid insufficiency was sought by the indicator-dilution technique. A bolus of indocyanine-green dye was injected into the right ventricle through a catheter placed just down stream from the tricuspid valve. Blood was withdrawn for dye curves from a transseptal catheter in the right atrium just up stream from the valve and from a needle in the femoral artery. The presence and severity of tricuspid insufficiency was determined grossly by comparison of the two dye curves. Tricuspid insufficiency was found in 28 of 90 patients and was judged to be mild in 11, moderate in 10 and severe in 7. Statistical comparison with 20 patients who did not have tricuspid insufficiency revealed that the insufficiency was progressively more severe with increasing right ventricular end-diastolic pressure, total pulmonary resistance, pulmonary artery pressure, right ventricular systolic pressure and pulmonary arteriolar resistance. Cardiac index decreased as insufficiency increased. There was no correlation with left atrial mean pressure, left ventricular end-diastolic pressure and the presence or absence of atrial fibrillation.

The present data is consistent with the hypothesis that rising pulmonary arteriolar resistance by producing pulmonary hypertension, right atrioventricular distention, and tricuspid insufficiency, diminishes forward flow and progressive overloading of the left atrium and pulmonary capillary bed. This would seem to support the clinical observation that patients with pulmonary hypertension have less orthopnea and paroxysmal nocturnal dyspnea once they develop tricuspid insufficiency.

This method of detecting the presence and severity of tricuspid insufficiency has been found to be reliable and sensitive. It should be of interest to the cardiac surgeon and may help direct his approach to the heart for corrective surgery. □



Familial Cardiomyopathy in a Milwaukee Family

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THE TERM "CARDIOMYOPATHY" has been reserved for a group of ill-defined disorders of cardiac muscle. Goodwin[1] has described this group to include "an acute, subacute or chronic disorder of the heart muscle of unknown or obscure etiology, often with associated endocardial or sometimes with pericardial involvement but not atherosclerotic in origin." Primary cardiomyopathy refers to involvement of *only* heart muscle while the secondary grouping involves multiple organ systems.[2]

A form of familial cardiomyopathy has been studied in several families and is said to be transmitted by autosomal dominant genes with incomplete penetrance[3,4] but sex-linked and autosomal recessive traits also have been reported.[5,6] This form has been called "familial obstructive cardiomyopathy" because of left or right ventricular outflow tract obstruction while Braunwald et al[7] have referred to this as familial idiopathic hypertrophic subaortic stenosis (IHSS). More recently, it has been suggested that the familial obstructive cardiomyopathies and the familial nonobstructive cardiomyopathies merely represent different manifestations of the same disease.[8,9]

Approximately seven years ago, one of the authors (WJG) became acquainted with members of the W family. This family grouping had heart disease of a mysterious nature which occurred in the young adults and manifested itself by sudden death at an early age. The present report attempts to delineate the extent of this disease in this family, to determine the mode of inheritance and to examine significant clinical characteristics of its presentation.

Subjects and Methods

The W family consists of 53 members spanning five generations (Fig 1). Thirteen persons have died; only one person available for study refused examination. The remaining 39 patients were examined in the six-month period preceding the writing of this paper. Five of these patients have been fol-

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Part of this study was done while Doctors Paul and Richer were senior students at the Medical College of Wisconsin.

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lowed for long periods (5–7 years) while the remaining 34 people were investigated as a result of this study.

A complete history and physical examination was done on all patients as was a 14-lead electrocardiogram, a plane chest roentgenogram and a Frank vectorcardiogram. Thirty-five subjects had a phonocardiogram. Two persons underwent cardiac catheterization (in 1961 and 1966) and these results were available for study. Two of the family members who have died had autopsies performed at another hospital.

Electrocardiographic criteria for left and right ventricular hypertrophy (LVH, RVH) were based on a point scale as described by Estes.[10] Vectorcardiographic calculations of the maximal spatial vectors to the right and left (RMSV, LMSV) were carried out according to the method of Hugenholtz[11] and loop rotations were compared to the normal values as listed by Guntheroth.[12] All data was analyzed for significance using the Yates correction for the chi-square distribution. Significant differences were established for a 95% confidence.

Results

A. Incidence

Ten of the 39 patients examined were considered to have cardiomyopathy on the basis of the studies performed. The patient who refused examination also was felt to be afflicted and she was recently hospitalized at another institution for unexplained congestive heart failure. Nine of 13 patients who have died had the illness; in 3 others, death was due to causes unrelated to the cardiovascular system and, in the final case, there was suggestive, but insufficient evidence for the disease. Four other living patients also had suggestive evidence but are not included as positive cases.

A total of 20 patients of the 53 family members (37%) were thus identified. Nine or 45% have died as a result of the disease. Five of these 9 deaths were sudden and unexpected. There was no significant sex difference.

The average age of patients examined was 14.5 years. The average age of those with definite evidence of the disease was 17.3 years and the average

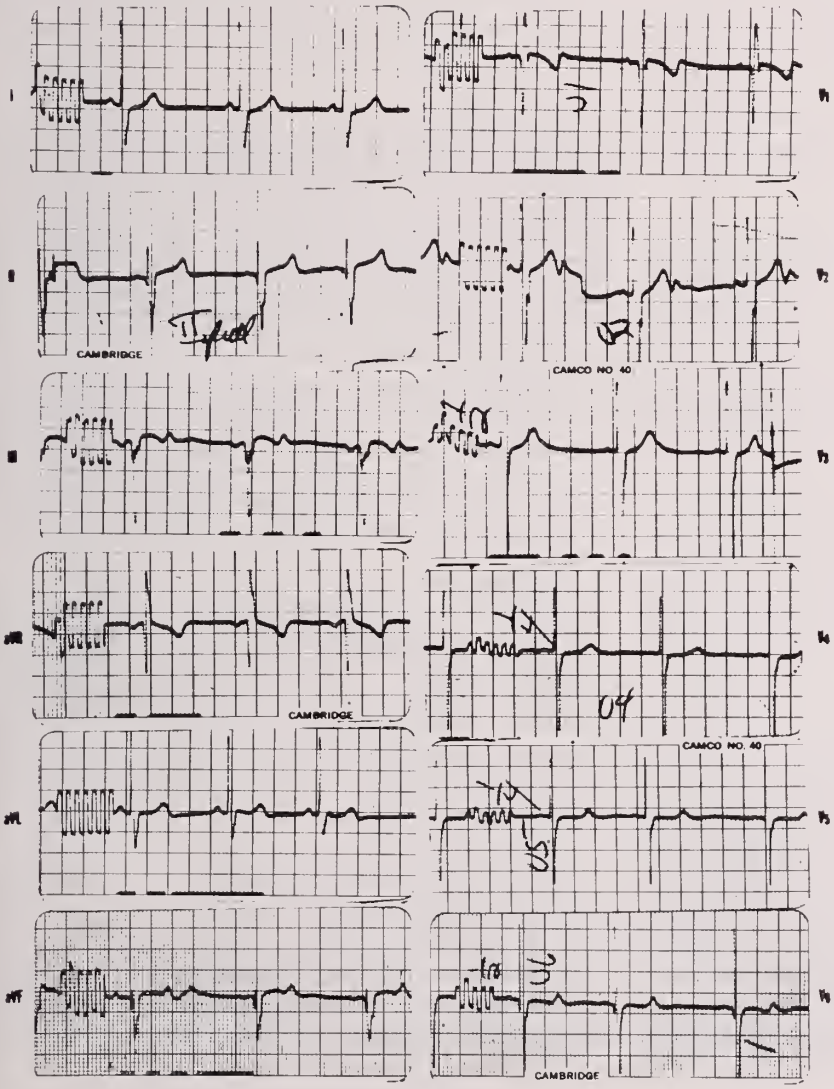

Figure 2—Electrocardiogram in patient V-15 (9 years old). Note left axis deviation, biventricular hypertrophy, deep 'q' waves and interventricular conduction delay.

TABLE 1—*Significant findings in familial cardiomyopathy in the W family*

HISTORY
1. Family history of early sudden death
2. Weakness (asthenia)
3. Dyspnea on exertion
4. Anginal chest pain
5. Syncope

PHYSICAL EXAM
1. Heart murmur—often nonspecific
2. Third heart sound

ELECTROCARDIOGRAM
1. LVH, RVH, or combined ventricular hypertrophy
2. Deep Q waves in leads I, II, III, aVL, aVF, V_5, V_6
3. ST–T wave changes
4. Left axis deviation

VECTORCARDIOGRAM
1. Increased maximal spatial vectors

TABLE 2—*Electrocardiographic and vectorcardiographic findings*

Patient	Age (yrs.)	Axis	LVH	RVH	Q Waves	Increased RMSV	Increased LMSV
III- 5	48	−65°	+				
IV- 8	24	+90°	+	+	+	+	
IV-12	31	+10°	+	+		+	+
IV-21	14	+30°		+		+	
V-11	11	+10°	+			+	+
V-12	10	+10°	+			+	+
V-13	8	−15°	+	+	+		
V-15	9	−45°	+	+	+	+	+
V-16	8	+65°					+
V-17	2	−30°	+	+	+	+	
Total			8	6	4	7	5

age of those dying from the disease was 25.1 years. Of the 4 sub-families (L, J, S and T) only one family (L) was disease free. The other 3 sub-families had a disease incidence of 33%, 55%, and 60% respectively.

Figure 2 lists the significant clinical and laboratory findings which contributed to the diagnosis of familial cardiomyopathy in this family.

B. History and Physical Examination

A review of the history did not offer any significant clues for the diagnosis. Of the 10 patients who were identified as having the cardiomyopathy and who were examined, there was a 30% incidence of dyspnea on exertion, 30% incidence of angina pectoris, 20% incidence of infrequent syncopal attacks and a 10% incidence of palpitations. Three patients (30%) were asymptomatic.

Two patients had an unusually forceful apical impulse, but none had a double apical impulse. Four patients (40%) had a loud third heart sound. No fourth heart sounds were detected. Eight of the 10 patients had murmurs either of an ejection type along the left sternal border or holosystolic at the apex.

C. Electrocardiogram

All ten patients examined with the disease had distinctly abnormal electrocardiograms. The most consistent finding was that of ventricular hypertrophy (9/10). Three patients had isolated left ventricular hypertrophy, one had isolated right ventricular hypertrophy, and the remaining 5 had combined ventricular hypertrophy. Left axis deviation was noted in 4 studies and all of these people were felt to have the disease. Coexistent with combined ventricular hypertrophy, 4 of 5 patients had abnormally deep Q waves in the standard and limb leads. Finally, 3 patients had ST–T wave changes as well as other evidence of electrocardiographic abnormalities. The electrocardiographic findings are summarized in Table 2 and an example of an abnormal cardiogram (V–15) is seen in Figure 2.

D. Vectorcardiogram

Maximum spatial vectors were increased in 8 of 10 patients and, in general, these corroborated the findings in the electrocardiogram. The average maximum spatial vector to the right was 1.9 mv (normal:0.6 mv) and the average maximum spatial vector to the left was 2.5 mv (normal:1.0–2.1 mv). This was, therefore, a significant difference.

E. Chest Roentgenogram

The chest roentgenogram was less helpful than one would expect in determining the presence of cardiomyopathy. In general, cardiothoracic ratios were increased in those patients with the disease (70%). However, on statistical analysis, this was not a significant difference from normal.

F. Phonocardiogram

All positive auscultatory findings were confirmed by phonocardiography. An additional third heart sound, not detected by auscultation, was noted in one patient (V–17). Of more importance was the fact that carotid pulse tracings were normal in all affected patients. No one had an abnormal ejection or upstroke time and there was not any evidence of a "double hump" contour.

G. Cardiac Catheterization

Two patients have had a cardiac catheterization and one has had a forward venous angiogram. One girl had a catheterization at age 8 years (V–11). The important findings included an elevated left ventricular end diastolic pressure and a thickened myocardium. There was no evidence for either mitral regurgitation or subaortic stenosis.

A second patient (IV–11) had an attempted catheterization at age 23 years but this had to be discontinued because of excessive bouts of ventricular tachycardia. He died three years later and at autopsy the diagnosis of cardiomyopathy was confirmed. A final patient (V–12) had a forward venous angiogram at age 9 years which revealed evidence of an enlarged interventricular septum and myocardial hypertrophy without any subaortic obstruction.

H. Deceased Patients

The outstanding common feature among these patients was sudden, unexpected death at an early age (Table 3). All patients were less than 35 years of age. The circumstances surrounding the death involved only mild strenuous activity such as walking or climbing stairs. In 2 of the patients, rheumatic fever had been suspected because of the presence of a blowing apical murmur of mitral regurgitation. One patient had bilateral femoral artery emboli from a thrombus in the left ventricle. The majority of patients were only mildly symptomatic with dyspnea on maximal exertion prior to the sudden exitus. In one of the deceased patients, autopsy confirmed the diagnosis of cardiomyopathy.

Discussion

The striking feature about this family is the occurrence of sudden death in 9 members, all of whom were under 35 years of age. It was this fact, when taking a history, which alerted one of the authors (WJG) to the probable existence of a familial problem. In addition to the deceased patients, 11 living family members also are felt to have the disease thus giving an incidence of 37%. The absence of any significant past or environmental history strengthens the diagnosis of primary familial cardiomyopathy. The incidence of 37% compared favorably with results of other authors who report a Mendelian dominant mode of inheritance.[3,8,9,13,14] Incomplete penetrance and variable expressivity explains the incidence of 37% as opposed to the predicted incidence of 50%.[8,13,15] Furthermore, many of our patients were very young (youngest was 6 months) and the disease does not often express itself before the second decade.

TABLE 3—*Age and circumstance at death of 9 deceased patients*

Patient	Age at Death (yrs.)	Circumstance
I- 1	Early 30s	
II- 1	34	
II- 2	Early 30s	
III- 3	16	Sudden death
IV- 5	25	Sudden death while climbing stairs
IV- 7	20	
IV-11	26	Multiple premature ventricular contractions at cardiac catheterization. Died following bilateral femoral artery emboli.
IV-15	17	Sudden death
IV-19	20	Sudden death while walking down street

The average age of those patients examined with the disease was 17.3 years as compared to 14.5 years for all patients examined. The average age at death for the 9 deceased patients was 25.1 years. The family described here is thus younger than that of Frank and Braunwald (26.8 years).[7]

Part of the difficulty in diagnosis lies in the paucity of physical findings and significant history. Thirty percent of our affected patients were asymptomatic. Vague dyspnea on exertion and angina were mentioned by 30% of patients which is thus not a significant finding. In those with a third heart sound (40%) this was an abnormal finding but in 6 of the 10 patients examined this was absent. Eight of 10 patients had a murmur but in only 3 was this an apical blow of mitral regurgitation. In the other 5, an ejection murmur was present which was easily confused with a semilunar flow murmur.[7,16] Double apical impulses, seen in patients with subaortic obstruction as a component of this lesion, were not noted.

The most helpful laboratory aid was the electrocardiogram whose findings were invariably verified by the vectorcardiogram. The major abnormalities noted were: (1) left ventricular hypertrophy, (2) right ventricular hypertrophy, (3) abnormally deep Q waves, and (4) ST–T wave changes. Mean QRS axis was of little help unless an axis of less than 0° existed (4 patients). Hollister and Goodwin[17] suggested that combined ventricular hypertrophy, left ventricular hypertrophy, prolonged Q–T intervals, sinus rhythm, and absence of heart block are indicative of "obstructive" forms while atrial fibrillation, bundle branch block, and first degree heart block are diagnostic of the "congestive" form. While our results suggest the obstructive type, we have no other evidence that this is really true. The elevated spatial vectors in the vectorcardiogram provided a good correlation with the ventricular hypertrophy seen on the electrocardiogram, a finding also noted by Kariv et al.[3]

We elected not to catheterize all of the patients because we did not feel it would contribute to either treatment or prognosis. The absence of subaortic obstruction even on an isoproterenol (Isuprel®) study, does not rule out an obstructive component to the disease. Moreover, if one accepts the fact that this is a single entity with a variety of expressions, patients with congestive forms could very well develop obstructive forms later in life. The sudden death in some family members suggests the onset of a sudden ventricular arrhythmia possible secondary to obstructive phenomenon. In the 2 patients catheterized, no evidence of subaortic obstruction was noted.

We have decided to treat the patients detected with cardiac involvement with propranolol, a beta-sympathetic blocker, even though there is no evidence of obstructive phenomenon.[18] We have done this because of our belief that this is a single entity with many forms of expression and that those patients with congestive phenomenon may develop the obstructive forms later. We plan to follow up results using "noninvasive" techniques and, if necessary, catheterization. With this treatment, we hope to retard or prevent further development of disease and hopefully, prolong life expectancy in the members of this family.

Evidence from this study shows the efficacy of investigating young children for cardiomyopathy, especially when there is an existing family history. Although the major manifestations of the disease may not express themselves until later, early detection is thus possible. On the other hand, whether the proposed treatment will be helpful remains to be seen.

Summary

A Milwaukee family of 53 members spanning four generations is presented. Twenty people have evidence for familial cardiomyopathy and 9 of these have died. Important clinical and laboratory findings are enumerated. The electrocardiogram and vectorcardiogram were the most useful tools for early detection. Sudden death was an outstanding common feature. The inheritance pattern is discussed and medical therapy with propranolol is suggested.

Addendum

Since submission of this article, patients 2 and 21 have died—both deaths were sudden and unexpected. The postmortem examination on patient 2 revealed evidence of myocardial hypertrophy. No postmortem was done on patient 21.

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MEDICAL SCENE IN WISCONSIN

UW Hospitals Develops New Cancer Treatment Program for Women

Physicians at University Hospitals (UWH), Madison, have developed a treatment program unique in Wisconsin for patients with cancer of the female genital tract.

Using an interdisciplinary approach, the service combines efforts of specialists in multiple fields including computers, to offer patients the most effective care for their individual needs. Gynecologic malignancy patients entering the hospital are seen by a gynecologist, a radiotherapist, and a chemotherapist. These specialists confirm the diagnosis and decide on a specific treatment plan.

UWH physicians treating genital tract tumors, use protocols developed from extensive information in a computerized data base. William F. Carr, director of the Gynecologic Computer Section, explained that the data base "is an invaluable source of information for determining effectiveness of a specific treatment program and long-term results."

Information on each patient, including the site and stage of malignancy, description of treatment and the patient's response and progress, is filed into the computer system. Physicians working with the patient later have immediate access to this information using a remote computer terminal on the nursing unit. Computer section personnel maintain the data base and keep a complete follow-up record on each patient during her life.

The ongoing program was initially funded by the Wisconsin Regional Medical Program and developed under the direction of Dr. Ben M. Peckham, chairman of the Gynecology–Obstetrics Department at University Hospitals.

Approximately 1,200 women are seen as inpatients or outpatients yearly in the department's Gynecologic Oncology Division, headed by Dr. Dolores A. Buchler. □

Comments on Treatment

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SHOCK: Pathophysiology and Treatment

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OVER THE PAST DECADE there have been several new concepts of the pathophysiology of shock which help to provide therapy on a more rational basis. Among these are (1) the unified concept of shock as being impaired circulation to tissues, rather than merely low blood pressure, (2) the realization that various vasoactive drugs have different effects on vascular tone and heart action, and (3) the description of cellular and biochemical changes which occur in irreversible shock. The following discussion is concerned with the hemodynamic changes associated with shock and with treatment based on sound physiologic principles.

Pathophysiology of Shock

The shock state relates to interference with circulation of organs and tissues to such an extent that normal oxidative metabolism is impaired. With inadequate perfusion, cell anoxia develops and cells in the peripheral circulation metabolize glucose anaerobically. This results in an intracellular accumulation of lactic acid and once compensatory mechanisms fail, a fall in pH. Note that blood flow and cellular hypoxia are emphasized with this definition, rather than arterial pressure.

From the above definition, one can readily see that any condition which reduces effective cardiac output can cause shock. Proper hemodynamics depend upon three interrelated factors: (1) cardiac output—an effective pump, (2) blood volume—effective circulating fluid, and (3) vascular tone—an open conducting system. Each of these factors

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greatly influences the others, and many checks and balances exist, e.g., a loss of blood volume is compensated by increased heart rate and vasoconstriction.

Space does not permit an extensive discussion of failure of the heart as an effective pump. Clinically, we recognize heart failure as being on the basis of infarction, arrhythmia, metabolic derangements, or sepsis. Once shock has become manifest, regardless of the cause, cardiac efficiency will not be improved until the metabolic effects of tissue anoxia are corrected.

Volume deficits result from external losses or are secondary to internal shifts of fluid from the effective circulating bed. Losses may consist either of blood or exchangeable sodium salts and water. Usually, the losses are both a combination of internal and external fluid shifts. In shock, sodium and water enter cells while potassium and lactate are forced into the serum. From a functional standpoint, this water and sodium loss is as if it had been external. This forms the basis for using large quantities of electrolyte-containing solutions in addition to replacement of specific blood contents in the treatment of shock.[1]

When the blood pressure falls, there are complex neuroendocrine responses which serve to restore pressure to former levels. The most significant of these are release of epinephrine and norepinephrine from the sympatho-adrenal axis. The primary effects of these vasoactive substances are to: (1) increase peripheral resistance through peripheral vasoconstriction and (2) to improve cardiac output by increasing heart rate and the force of myocardial contraction. This results in diversion of blood from the kidney, bowel, and extremities to more vital areas such as the heart and brain. This selective ischemia is necessary for immediate survival but becomes detrimental if shock is prolonged or untreated, because it perpetuates cellular anoxia and acidosis.

In addition to receptors regulating vasoconstriction, some organs have receptors which produce vasodilatation. The former receptors are called alpha receptors and are most prominent in the vessels of the splanchnic area; the latter are called beta receptors and are more prominent in skeletal vessels and heart. Alpha receptor stimulation causes vasoconstriction, increased peripheral resistance, elevation of blood pressure, venous pooling in the capillary bed, and indirect slowing of the heart. Beta receptor stimulation, on the other hand, causes vasodilatation, a fall in blood pressure, decreased venous pooling, and increased heart rate. The concept of alpha and beta stimulation is important because 70–80% of the blood volume is harbored in the venous (capacitance) circuit. Evidence indicates that initial vasoconstrictive stimuli produce increased resistance in both arterial and venous sphincters on either side of the capillary bed. However, with untreated shock, acidosis increases. The arterial precapillary sphincter mechanism is apparently more sensitive to low pH than the venous sphincter mechanism, and thus selectively loses its tone in the face of increased acidosis. This allows blood to flow into the peripheral circulatory system, but venous constriction hinders its return to the heart, and consequently blood is trapped or pooled in the peripheral circulation.[2] Beta receptor stimulation or alpha blockade can be used to prevent stagnation of blood under these conditions and thus increase cardiac output.

Currently, there is a group of drugs clinically useful in the treatment of shock which work by altering alpha or beta responses.[3] Methoxamine (Vasoxyl®) and phenylephrine (Neosynephrine®) are primary alpha adrenergic drugs. Isoproterenol (Isuprel®) and mephanteramine (Wyamine®) are beta adrenergic drugs (beta mimetics). At one dose some drugs are powerful beta stimulators, and in higher doses they are alpha stimulators. Examples of this are norepinephrine (Levophed®), epinephrine (Adrenalin®), and metaraminal (Aramine®). Some drugs block alpha receptor stimulation and are known as alphalytics. They cause vasodilatation as do beta mimetics, but unlike them, lack significant cardiac-stimulating properties because the heart has no alpha receptors. Examples are chlorpromazine (Thorazine®), phentolamine (Regitine®) and phenoxybenzamine (Dibenzyline®). Betalytics, such as propranolol (Inderal®), primarily block cardiac receptors and are very useful in arrhythmias. Corticosteroids fit into the above system because they are felt to have alphalytic action peripherally and seem to have a beta mimetic effect on the heart centrally. In addition, they stabilize the lysomal membrane of the cell wall and thus prevent release of damaging proteolytic enzymes from anoxic cells.[4]

It has been proposed that once shock has become profound, vasoactive endotoxins from the intestines are not detoxified because of ischemia of the reticuloendothelial system and thus aggravate the already existing conditions.[4] Poor perfusion results in stagnation, coagulation, and eventually necrosis and disruption of the cellular wall of vessels and the tissues they perfuse, and once this occurs, shock is considered to be refractory to all therapy.

Evaluation of the Shock Patient

Although many sophisticated techniques for evaluation of the patient in shock exist, most hospitals are not equipped to quantitatively assess shock.

However, basically simple bedside techniques can be useful in the diagnostic appraisal of the patient. Peripheral resistance and blood flow can be easily evaluated by examining the patient. Blood flow to skin reflects pulmonary, renal, and splanchnic circulation. A urine volume below 25–30 ml/hour suggests inadequate visceral blood flow. Cerebral blood flow can be evaluated by level of consciousness, and cardiac output roughly by pulse pressure. Central venous pressure readings relate to the functional adequacy of blood volume in relation to the pumping capabilities of the heart.

Simple laboratory techniques such as arterial blood gases can be helpful in evaluating the metabolic and respiratory changes and compensatory mechanisms which occur in the shock state. Serial hematocrits may be helpful in evaluating hemorrhagic shock, but it must be remembered that it takes time for hemodilution to occur, and thus a normal hematocrit may be meaningless in the initial evaluation of the shock patient.

Treatment

If one assumes the unified concept of shock as being decreased perfusion of vital organs which results in accumulation of acid metabolites, then regardless of the etiology, the major goal of therapy is to increase the effective blood flow to organs and tissues. Weil's[5] "VIP" formula paraphrases the essential steps of treatment: Ventilate, Infuse, and Pump. He parenthetically adds "PS": Pharmacologic Drugs and Surgery as sometimes being useful in the treatment of shock.

Ventilate: to provide adequate oxygen to tissues and to compensate for metabolic acidosis by blowing off excess carbon dioxide.

Infuse: to restore effective circulating blood volume. Replace with the same type of fluid lost whenever possible. However, in hemorrhagic shock, type specific blood may be used if the need is urgent enough. In addition, sodium-containing crystalloids should also be infused to offset the translocation of water and sodium into the cell.[6] The resultant drop in hematocrit does not significantly reduce the oxygen transport to tissues if it is kept in the 25–30% range. A low hematocrit is better than no flow at all. In addition, the hemodilution helps prevent stagnation and intravascular coagulation. However, moderation must be used in the amount of noncolloid fluids infused because heart failure and pulmonary edema may result.[7] The amount replaced should therefore be monitored by urine output and central venous pressure.

Pump. Since the heart will not work effectively in the face of acidosis, correction with bicarbonate becomes mandatory. Cardiac function can also be improved with 1–2 mg of isoproterenol (Isuprel®) in 500 mg of dextrose and water. Since this drug is beta adrenergic, the heart rate and force of contraction will be increased, but blood pressure may fall due to its peripheral effects. Therefore, certain precautions should be exercised while using isoproterenol. One should maintain a normal blood volume and a normal serum potassium. Serious blood pressure problems may occur when the inotrophic response of a depressed myocardium is absent, but peripheral vasodilatation is still present. In addition, there may be serious and fatal arrhythmias due to hypokalemia. Therefore, when using isoproterenol (Isuprel®), the CVP, blood pressure and electrocardiogram must be constantly monitored.

In cardiogenic shock after a myocardial infarction, norepinephrine (Levophed®) may be more effective than Isuprel® in maintaining coronary blood flow and myocardial oxygen if used for only a short period of time and early in the shock state. Recent evidence suggests that Isuprel® may extend the area of infarction.

Intravenous digitalis is indicated in cardiogenic dysfunction. Adequate circulation should be maintained with an isoproterenol (Isuprel®) drip until full digitalization is reached in the shock patient.

Vasoactive drugs have been misused in shock for a long time. Their use is often required and is still a matter of great controversy. Shock associated with peripheral vascular failure may be divided clinically into two groups: those with initial vasodilatation and those with initial vasoconstriction, followed later by vasodilatation. The former is a relatively rare condition and is associated primarily with spinal anesthesia and gram-positive sepsis. These are the only conditions in which it appears logical to treat with vasoconstrictors to restore the vascular tree. As noted previously, vasoconstrictors also may be indicated early in coronary cardiogenic shock. Shock associated with untreated hypovolemia, gram-negative sepsis, or cardiac failure already has maximal vasoconstriction, and it appears more logical to treat these more common causes of shock with agents that will increase perfusion and correct metabolic acidosis. If the circulatory blood volume is adequate (as measured by a CVP over 10.0 cm of water) then benefit may be derived by the use of vasodilators. Pharmacologic doses of corticosteroids, e.g. methylprednisolone (Solumedrol®) in doses of 30 mg/kg have been suggested as being particularly useful in septic shock.[2] Other drugs having an alphalytic action, such as chlorpromazine (Thorazine®) or phenoxybenzamine (Dybenzaline®) also may be effective. It should be pointed out, however, that their use to date has not met uniform acceptance.

Broad *antibiotic coverage* should be instituted if sepsis is the cause of shock. Specific antibiotics should be used once the causative organisms are identified. If there is continued contamination (e.g. spreading peritonitis or abscess formation), *surgery* may be necessary, even in the face of clinical shock.

Summary

A rational therapeutic approach, which applied clinically the current information of the pathophysiology of shock, has been presented. This paper discusses the unified concept of shock, various fluid shifts, and the use of vasoactive drugs in some of the cellular and metabolic changes that occur in irreversible shock.

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July 1972 through December 1972

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN—BUREAU FOR CRIPPLED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	
Stevens Point	Aug. 16	F. W. Reichardt, MD
Ashland	Aug. 24–25	W. T. Brodhead, MD
Superior	Sept. 19	J. G. Heisel, MD
Chippewa Falls	Sept. 26	J. M. Huffer, MD
Eau Claire	Sept. 27	G. L. Lucas, MD
Racine	Oct. 11	C. W. Christenson, MD
Racine	Oct. 12	M. W. Nelson, MD
Manitowoc	Oct. 16–17	W. F. Schneider, MD
Kenosha	Oct. 25	C. A. Sattler, MD
Kenosha	Oct. 26	L. T. Schlenker, MD
Rhinelander	Nov. 1–2	H. I. Okagaki, MD
Sheboygan	Nov. 8–9	J. J. Van Driest, MD

FOR: Clinics conducted by the Bureau for Crippled Children of the Division for Handicapped Children are for persons under 21 years of age for orthopedic diagnosis and consultation. Reports of the examinations are sent to the family physician following the clinic.

REFERRAL FORMS: Referral forms may be obtained from the Division for Handicapped Children and should be requested well in advance of the clinic date. Referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

NOTE: As of January 1, 1972 we no longer require the signature of a physician on the referral form. We would appreciate, however, the name and address so we can send the report to him.

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The Diagnostic Importance of the Hepatic Friction Rub

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THE HEPATIC FRICTION RUB is seldom mentioned in the literature.[1-4] This article describes its occurrence in four patients who had liver metastasis. This experience leads to the conclusion that hepatic friction is not uncommon and that it is most likely to occur when there is metastatic involvement of the liver.

Case 1

A 73-year-old black woman was admitted for the second time for further treatment of colonic colloid carcinoma. Six months prior to this admission she had had a colonic resection. At that time liver biopsy failed to reveal evidence of metastasis. She had been followed in the Tumor Clinic where she received hydroxyurea therapy. There appeared to be no satisfactory response to this medication as a chest x-ray film revealed pulmonary lesions compatible with lung metastasis. Physical examination showed a weak, disoriented, elderly woman. Her blood pressure was 140/90 mm Hg, pulse 80, temperature 98 F. There was abdominal tenderness in the sub-xiphoid area and around the umbilicus. The liver was palpable 4 cm below the right costal margin in the anterior axillary line. There was a firm, irregular, tender mass in the right upper quadrant. A hepatic friction rub was present over the sub-xiphoid area. It was not palpable.

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The hepatic friction rub persisted for four days after which it was not heard. The patient died on the fifteenth hospital day, and at autopsy the liver was huge with widespread metastatic adenocarcinoma. Over the anterior surface of the liver there was an irregular area of necrosis.

Case 2

A 54-year-old black porter was admitted because of low back pain of four weeks duration. The pain was sharp with radiation to the right side of the abdomen and right hip and was aggravated by movement. Because of fever and profuse diaphoresis, he presented himself to the hospital admitting office.

On examination he appeared dehydrated and chronically ill. He was tachypneic and lethargic. His blood pressure was 115/70 mm Hg, pulse 124, temperature 101.2 F and his respiratory rate 30/minute. There were numerous subcutaneous tender nodules along the right side of the chest. There was dullness to percussion with decreased breath sounds over the right side of the chest. The liver was felt 3 cm below the right costal margin in the anterior axillary line. It was slightly tender. A hepatic friction rub was heard over the right costal margin.

Biopsy of a subcutaneous nodule was carried out on the third hospital day. This showed undifferentiated adenocarcinoma. Several thoracenteses and pleural biopsies were performed which were negative for malignant tissue.

The patient deteriorated rapidly and died on the fifth hospital day. Postmortem examination showed that the source of the malignancy was the right mainstem bronchus and that there were widespread metastases to the liver, bones, and right pleural space. There was a small 3-cm zone of necrosis over the anterior surface of the liver.

Case 3

A 33-year-old black woman was admitted for the first time because of weakness of the lower extremities. She gave the history that she had been a chronic wine drinker for thirteen years and had been unable to eat properly for the last six months. In addition she gave the information that she was a heavy cigarette smoker.

On physical examination she was thin and cachectic. Her blood pressure was 130/90 mm Hg. Her pulse was 120 and regular. Her temperature was 100.2 F. Examination of the heart was normal. There was dullness at the right lung base with fine rales in this area. The abdomen was full and firm. The liver was huge with its lower margin felt about 14 cm below the right costal margin. It was firm, with a sharp edge and nontender. A two component hepatic friction rub was audible over the xiphoid area. The rub was leathery in quality and became more prominent with deep respiration and soft with shallow respiration. The spleen was not palpable. Neurologic examination showed a decrease in pain sensation in the lower extremities. Motor examination showed bilateral weakness of the lower legs.

On the sixth hospital day a liver biopsy was performed which showed an adenocarcinoma infiltrating the liver. On the eighth hospital day the patient suddenly became confused and disoriented. A day later she died. Postmortem examination showed a bronchogenic carcinoma with widespread metastasis including the liver. There were several areas of necrosis on the anterior surface of the liver.

Case 4

A 44-year-old caucasian man was admitted with the chief complaint of abdominal distention and loss of appetite of four weeks duration. The patient stated that he had lost his taste for food but had forced himself to eat one meal a day. During that period, he had noted an increase in girth which was associated with a constant dull abdominal pain, most pronounced in the epigastric area, and aggravated by eating. He denied nausea or vomiting. He had a sensation of abdominal fullness. The stools had become lighter in color and less frequent in number. With increasing girth he noted progressive shortness of breath, and a decrease in exercise tolerance. No change in urine or skin color had been noted. He denied a history of alcohol intake.

He was a well developed, chronically ill appearing man, with moderately icteric sclerae and a protuberant abdomen. His blood pressure was 140/110 mm Hg, pulse 104, and respirations 20. Skin was sallow, yellowish in color. There was decreased axillary and pubic hair. Scattered spider naevi were noted on the chest. There was no gynecomastia. The trachea was in the midline. There were moist rales in the left base with dullness to percussion in the same area. There were absent breath sounds in the right base and decreased tactile fremitus. The heart was not enlarged. There was a grade 2/6 pansystolic apical murmur. A fourth heart sound was noted at the apex. The abdomen was distended. There were dilated veins over the abdominal wall. Shifting dullness and a fluid wave were present. There was slight tenderness in the epigastrium. No masses could be palpated. There was testicular atrophy. The rest of the examination was negative.

By the seventeenth hospital day a significant diuresis had been achieved with a considerable decrease in the ascites. It was then that a sub-xiphoid friction rub was noted. This could also be palpated in the epigastric region. At this time the liver was noted to be 12 cm below the right costal margin in

the mid-clavicular line. It was firm and its surface was nodular. Two days later the patient began to have hypotensive episodes which required vasopressor agents to control. He died on the twenty-second hospital day. At postmortem examination pancreatic carcinoma was found with widespread intraabdominal metastasis, which included the liver. Histological examination showed that this was a poorly differentiated adenocarcinoma. In addition, there was evidence of post-necrotic cirrhosis with focal areas of coagulation necrosis.

Comment

These observations suggest that a hepatic friction rub is strong evidence in favor of the presence of metastatic tumor in the liver. The four cases described in this paper were gathered over a period of four months on a general medical ward. If this sign were looked for in patients with an enlarged liver, it is likely that a much higher incidence would be noted. Abdominal auscultation does, however, seem to be neglected.

Fenster and Klatskin[4] observed this sign in 8 of 81 patients with biopsy proven liver metastasis. Fred and Brown[3] have reported its presence in a case of hepatoma and have commented that the hepatic friction rub is probably common with primary hepatic carcinoma.

Although this clinical sign is mentioned as early as 1905,[5] there appears to have been little written regarding its usefulness in clinical medicine.[1–7] It is usually leathery in character but may be described as the crunching of new snow. Most commonly it is noted over an enlarged nodular liver. It may be accompanied by pain which is aggravated by breathing, coughing, or movement. It occasionally is palpable. With excursion of the liver during respiration the rub may intensify. As with pericardial friction rubs, the sounds may last for days or be evanescent. As fluid accumulates, it disappears; or it may appear as ascitic fluid volume diminishes, as seen in case 4. This suggests that peritoneal contact is essential for friction noise.[6]

These observations agree with those of Fenster and Klatskin[4] that metastatic tumor of the liver is the most common lesion causing a hepatic friction rub. It is suggested that the hepatic friction rub is an important clinical sign and should be looked for regularly in patients with undiagnosed hepatomegaly.

Summary

A hepatic friction rub was heard in four patients with proven liver metastasis. It is suggested that this overlooked clinical sign is important evidence pointing to hepatic neoplasia.

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MEDICAL SCENE IN WISCONSIN

New Diagnostic Procedure for Cancer Performed in Marshfield

A new medical procedure which will save the patient hundreds of dollars and reduce his hospital stay four to six days was performed recently at the Marshfield Medical Center.

Robert Norfleet, MD, a Marshfield Clinic gastroenterologist, assisted by Dale Mulholland, gastroenterologic technologist, removed colon polyps from two patients using an instrument called a fiberoptic colonoscope. He said it was only the second time the procedure has been used in the state, the other having been performed in a Milwaukee hospital in July.

This operation, including time in the recovery room, generally takes six to eight hours. With the new procedure, the physician can remove the entire polyp through the rectum so that the lesion may be studied for cancer. The procedure is accomplished within one and a half hours and permits the patient to be discharged 24 hours later. The patient is admitted to the hospital the previous evening where he is given standard preparation for a colon x-ray. No general anesthetic is required with the new procedure and only mild sedation is necessary, Doctor Norfleet reported. □

Teenage Drug Abuse in Middle Class Milwaukee

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AT THE START of this study it was anticipated that a broad and representative sample of high school youth in the Milwaukee metropolitan area would be surveyed in an effort to ascertain the nature and degree of teenage drug abuse in this community. To accomplish this, the cooperation of the Milwaukee Public School System was needed; and at the last minute this organization decided not to participate. As a result, our efforts had to be confined to the public schools in the surrounding communities as well as private schools within the city where permission and cooperation were obtained. Naturally, this dramatically altered the character of the available population and restricted our original objectives. This article does not attempt to portray the drug picture of the entire metropolitan area; but it does, we believe, give a true reflection of what the picture was in the middle and upper middle class at the time the survey was conducted.

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TABLE 1: *Grade–sex distribution of students*

	GRADE				
	9th	10th	11th	12th	Total
Male	809	970	948	821	3,548
Female	523	733	632	605	2,493
TOTAL	1,332	1,703	1,580	1,426	6,041

Methods

Permission was obtained from the school board of a number of neighboring communities as well as from the principals of a group of private schools within the city of Milwaukee. Particular schools were chosen in an attempt to survey students in all geographic directions from downtown Milwaukee. The vehicle used was a specially made questionnaire that the student anonymously completed. The data was transferred to punch cards and analyzed by computer at the Biomedical Computer Center of the Medical College of Wisconsin.

In every instance the principal, guidance staff, and certain faculty members were consulted to discuss the data collected. In one instance a followup random sample was performed at one school where about 10% of the students were personally interviewed in an effort to see if results equivalent to the questionnaire method could be obtained. Comparing the results of the various schools with each other as well as the results of a particular school with other data collected on the student body of that particular school, it is believed that our data is both reliable and valid.

The Students Participating

This article reports the data collected at six Milwaukee area high schools; comprising a total of 6,041 participating students. A grade–sex distribution of students is depicted in Table 1.

Due to the above mentioned restriction, the racial composition of the participating students is definitely skewed—97.3% being white. About 56% of the students came from families with a reported income greater than $10,000 a year, and 18% came from families with an annual income over $20,000.

All of the schools involved had enrollments which were predominantly Roman Catholic; however, it was found that in our study the incidence of drug experimentation was not a function of religion or being religious. Similarly, over 92% of the students planned on enrolling in college upon completing high school; however, neither ambition nor achievement was a factor in drug abuse in our population.

In addition to family income, religion, and educational objectives (none of which were significant) a group of other parameters was measured in an attempt to discover significant cross tabulations with drug usage. These parameters consisted of with whom the student resided, number of friends, family size, future career objectives, degree of dependence, as well as music and sports interest. There were no significant relationships between any of these factors and drug experimentation, and in our study group there were not enough really heavy abusers to draw conclusions between the light user and the gross abuser.

Tobacco and Alcohol

Prior to questioning the students on the better known street drugs, we first attempted to gather information on their cigarette smoking and drinking habits.

It was interesting to learn that 52% of the students had never smoked cigarettes and that an additional 22% had smoked in the past but quit. Only 6% of the students would admit to smoking more than 5 cigarettes daily. Unremarkably, of the students who did smoke, the lighter smokers tended to be females and the heavier smokers were males. Furthermore, the prevalence of cigarette smoking, especially heavier smoking, tended to increase with age. The cigarette smoking data

TABLE 2: *Student alcohol consumption*

Grade	Percentage of students who drink at least monthly
9th	45
10th	56
11th	66
12th	73
TOTAL	62.5

tends to agree with evidence found elsewhere that cigarette smoking truly is a "dying" habit.[1]

Perhaps the most revealing findings in this study dealt with the student usage of alcohol. It is noteworthy that a total of 62.5% of the students conceded that they used alcohol in some form at least occasionally, and none of these students had yet reached his 21st birthday.† Interestingly, the only difference between male and female usage was that males tended to drink more frequently though equal percentages of both sexes drank. Furthermore, there were also significant differences between the grades as is exemplified in Table 2.

This was the most significant area of drug abuse discovered, and it seems to substantiate what has been described as America's most destructive drug problem.[2]

†Legal age at time of study.

The students were asked to describe the alcohol consumption pattern of their parents, and these findings are shown in Table 3.

Whether parental drinking habits influenced the students was not investigated in this study.

Street Drugs

When confronted with the question of whether they had ever taken an illegal drug other than alcohol, 21.5% of the students said that they had. The range of affirmative responses from the various schools was from a low of 15.7% to a high of 36.2%. Both of these schools were coeducational, public schools located in the Milwaukee suburbs. We next attempted to identify which drugs were being taken, and these findings appear in Table 4.

There are significant differences between grades as noted in Table 5.

If this trend is extrapolated, it would concur with findings seen on college campuses where better than 50% of the students polled admitted to having tried an illegal drug.[3] These college polls tend to show the most popular drug as being marijuana.

In high school, approximately one student in five has tried marijuana; and our data showed no significant difference between the sexes for use of this drug. Significant differences did exist for certain other drug groups: females were more likely to use amphetamines and barbiturates, whereas males would be more likely to use hard narcotics and hallucinogens.

Males tended to first take an illegal drug while in the 10th grade whereas females were more often in the 9th grade. This is not surprising since the drug scene is often a social phenomenon, and it is common to find high school girls dating boys a grade higher. In our study, only 4.3% of the students first took an illegal drug while still in elementary school.

When asked how much money was spent on drugs, there was no significant difference between the sexes for sums less than $15 per week. At sums greater than this the males tended to be more conspicuous; however, less than 11% of all of the drug users spent more than $15 per week.

Reasons for Drug Abuse

All students were asked a series of questions in an effort to learn why drugs were being taken and what effects, if any, were being achieved. The reasons for first taking an illegal drug other than alcohol are shown in Table 6.

TABLE 3: *Parental alcohol consumption*

Degree of Usage	Percentage Mothers	Percentage Fathers
No alcohol consumption	12	8
Light, social drinking	81	77
Heavy to excessive drinking	3	10
Unknown or no response	4	5
TOTAL	100	100

TABLE 4: *Student usage of street drugs*

Drug	Percentage of Usage				
	Once	Occasional*	Often*	Regular*	Total
Marijuana	5.1	5.6	3.6	4.3	18.6
Amphetamines	2.8	3.2	0.8	0.8	7.6
Barbiturates	3.0	2.5	0.6	0.5	6.6
Hallucinogens	2.1	2.5	1.0	0.8	6.4
Opium	1.8	1.8	0.3	0.5	4.4
Glue	2.3	0.6	0.2	0.4	3.5
Codeine	1.6	1.2	0.1	0.3	3.2
M.D.A.	1.2	0.8	0.3	0.2	2.5
Hard Narcotics	0.8	0.7	0.4	0.3	2.2
Catnip	1.4	0.4	0.1	0.2	2.1
Cocaine	0.9	0.7	0.1	0.3	2.0

* Occasional—once a month or less frequently
Often—at least twice a month, but not weekly
Regular—at least once a week

TABLE 5: *Drug abuse by grade*

Grade	Percentage who have used illegal drugs other than alcohol
9th	11.7
10th	17.3
11th	22.3
12th	32.8
TOTAL	21.5

TABLE 6: *Reasons for first experimenting with drugs*

Reason	Percentage of Concurrence
Curiosity, to see what it's like	47.7
To be accepted	19.8
Immediate escape	18.5
On a dare, to show off	10.2
Other reason	3.8
TOTAL	100

TABLE 7: *Reasons for continued drug usage*

Reason	Percentage of Concurrence
Escape	40.3
Happiness	26.5
Creativeness	8.9
Distortion	8.1
Forgetfulness	6.6
Boldness	5.1
Other	4.5
TOTAL	100

It was then asked why drugs were continued after the initial experimentation, and these reasons are shown in Table 7.

The findings in Tables 6 and 7 concur with findings of other surveys.[4,5]

Adverse Reactions

When questioned on the subject of adverse reactions, 19.7% of the drug users said that they had encountered a "flash-back" some time after a drug experience. Also, 18.5% of the users admitted to having had at least one "bad trip" or "bummer" in their experience with drugs.

Effects of Drug Usage

We were interested in learning whether drug users felt that certain parameters varied while under the influence of a drug, and these findings are shown in Table 8.

Drug Availability

A total of 76% of the students surveyed said that they could obtain drugs if they so desired, and 70% said they could get these drugs in school. When asked how many students at their school were drug users, most of the students guessed within ten percentage points of what our study demonstrated. The students also were asked a series of questions to reveal their understanding and knowledge of the drugs being used and abused, and the results of this line of questioning will be the subject of a future article.

TABLE 8: *Alterations due to drug usage*

Parameter	Percentage experiencing an Increase	Percentage experiencing an Decrease	Percentage no change	Percentage TOTAL
Ability to communicate	45.8	15.0	39.2	100
Amount of physical contact	34.3	13.1	52.6	100
Enjoyment of physical contact	42.5	11.0	46.5	100
Sexual activity	39.3	10.6	50.1	100
Appetite	38.3	29.9	31.8	100

Summary

Six senior high schools in the Milwaukee metropolitan area were surveyed in an attempt to ascertain the prevalence of teenage drug abuse in middle class Milwaukee youth. In addition to learning that 74% of the students surveyed did not smoke at all and that 62.5% consumed alcohol at least occasionally, it was discovered that 21.5% had experimented with street drugs, most commonly marijuana. Males were most likely to begin illegal drug usage in the 10th grade, females in the 9th grade; and the reason most often cited for the original experimentation was curiosity, to see what it's like. The reason most often given for continued drug usage was escape. It was also learned that 76% of the students polled said that they could obtain illegal drugs if they so desired.

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Subtotal Sternal Resection for Metastatic Renal Cell Carcinoma

CHARLES E YALE, MD, DSc and JOHN B WEAR, JR, MD, Madison, Wis: *Arch Surg* 105:87–89 (July) 1972

Two elderly males with a pulsating sternal mass secondary to an apparently solitary metastasis from a small hypernephroma of the left kidney were treated in 1966, at 69 and 80 years of age. Each man had a left nephrectomy and an excision of the manubrium of the sternum. Over five years later, both patients are alive, and, after careful follow-up examinations, found to be asymptomatic and without evidence of residual or recurrent tumor.

To our knowledge, these are the first reported five-year survivors following subtotal resection of the sternum for a metastatic lesion. Although most sternal metastases should not be resected because of widespread disease, these two cases demonstrate that subtotal sternal resection may be helpful for an apparently solitary metastasis, particularly from a renal cell carcinoma. □

POSITION PAPER of The American Dietetic Association

Bland Diet in the Treatment of Chronic Duodenal Ulcer Disease

THE BLAND DIET and its modifications have been used for many years as part of the treatment for duodenal ulcer and other gastrointestinal disorders. It has most often been defined as one which is chemically and mechanically non-irritating; however, there is considerable lack of agreement as to which foods are actually non-irritating. Review of diet manuals from many states reveal regional differences as to foods allowed. In reviewing the literature, it is noted that much of the rationale for the bland diet is based on tradition and even folklore.

The American Dietetic Association, in its commitment to interpret and apply the science of nutrition in the promotion of individual, group, and community health:

I. Recognizes that the rationale (chemically and mechanically non-irritating) for the bland diet is not sufficiently supported by scientific evidence.

A. Spices, condiments, and highly seasoned foods are usually omitted on the basis that they irritate the gastric mucosa. However, experiments have indicated that no significant irritation occurs, even when most condiments are applied directly on the gastric mucosa. Exceptions are those items which do cause gastric irritation, including black pepper, chili powder, caffeine, coffee, tea, cocoa, alcohol, and drugs.

B. Milk has been the basis of diets for duodenal ulcer for many years. One of the primary aims in dietary management of duodenal ulcer disease is to reduce acid secretion and neutralize the acid present. While milk does relieve duodenal ulcer pain, the acid neutralizing effect is slight. Its buffering action could be outweighed by its ability to stimulate acid production. Most foods stimulate acid secretion to some extent; protein provides the greatest buffering action and is also the most powerful stimulus to acid secretion. The use of milk therapy has been greatly reduced over the past decade, owing to a better knowledge of its side effects and allergic reactions. The controversy regarding the use of milk still continues. There are those who still advocate the regular use of milk, primarily during the active stage of acute duodenal ulcer; however, strict insistence on its use during remission is unwarranted.

C. Roughage, or coarse food, has been excluded from the diet on the basis that it aggravates the inflamed mucosal area. There is no evidence that such foods as fruit skins, lettuce, nuts, and celery, when they are well masticated and mixed with saliva, will scrape or irritate the duodenal ulcer. Grinding or puréeing of foods is necessary only when the teeth are in poor condition or missing.

D. The effect of a bland diet on the healing of duodenal ulcer has been studied extensively. Investigations have compared various bland diets with regular or free-choice diets. The results indicate that a bland diet made no significant difference in healing the ulcer. One such study demonstrated that the acidity of the gastric contents was frequently lower when a free-choice diet was taken. Many foods have been incriminated as the cause of gastric discomfort and are subsequently eliminated from a patient's diet. Studies done on patients with and without documented gastrointestinal disease indicate that those with gastrointestinal disease cannot be distinguished by food intolerance. Symptoms of intolerance were more related to individual response than to intake of specific food or the presence of disease.

II. Believes that scientific investigation supports the validity of frequent, small feedings in the management of patients with duodenal ulcer disease. These have been found to offer the most comfort to the patient; additionally, acidity of the gastric contents is lower with small-volume, frequent feedings. It must also be recognized that rest, preferably in bed, rapidly reduces duodenal ulcer symptoms. This is a specially important factor in the healing of the ulcer.

III. Believes the following points should be of major consideration in developing a dietary plan for duodenal ulcer patients.

A. Individualization of the dietary plan, since patients differ as to specific food intolerances, living patterns, life styles, work hours, and education.

B. Utilization of small volume, frequent feedings.

C. Provision of educational materials relative to dietary support.

IV. Advocates the continued pursuit of current research and recommends that valid information be utilized in up-dating dietary regimens.

V. Suggests that dietetic practitioners be cognizant of the possible harmful effects of a milk-rich bland diet in patients who have a tendency towards hypercalcemia and/or atherosclerosis. □

Approved by the Executive Board of the American Dietetic Association, May 21, 1971, as Position Paper Number 0000H.

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Distribution of Biochemical Values as Determined by the Wisconsin Multiphasic Screening Program 1968-1970

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THE OBJECTIVE OF THE Wisconsin Multiphasic Case Finding Program, carried out by the Bureau of Preventable Diseases, State Division of Health, is to identify individuals with a high probability of having certain diseases.

The program utilizes the Technicon SMA 12/60 autoanalyzer capable of rapidly measuring concentration of a number of chemical components in blood serum, with acceptable accuracy and at relatively low cost. Blood serum samples are sent to the State Laboratory of Hygiene from mobile units situated at various sites throughout the state.

Through the years 1968 to 1970, about 8 to 10 percent of the participants in the screening program were referred to their personal physicians. From the more than 4,000 physicians' reports received at the Bureau, two out of three persons examined were found to have a disease condition.

The table accompanying this article describes the statistical distribution of biochemical values found in processing more than 80,000 blood serum samples in the program. The slight difference in frequency of extreme values can be explained by variations in specimen shipment, storage, handling chemicals at the laboratory, and in techniques used. However, data collected from 80,000 measurements provide reliable statistics for conditions which are relatively rare.

It should be pointed out that the association of disease condition with given biochemical values does not always follow the statistical "normal" distribution of values. Rather, the table of values indicates the frequency of certain measurement results in the population participating in the program.

Comments on the distribution of values by individual chemical tests follow:

Cholesterol

This test is one of the most useful determinations in the screening programs. Mean values and confidence limits observed are very close to data published in other literature.

The highest mean values are found among males in the age group 45 to 54. Mean values and the standard deviation are lower after this age in males, whereas for females there is a steady increase of mean values by age.

The possibility that a portion of the male population with high cholesterol values die from coronary heart disease at an early age is considered. This may cause a lower proportion of persons with high cholesterol values among older males.

The mean values up to the age of 55 years are higher for the males. Above this age females have higher mean values.

Of the males over 65 years of age, 11.6 percent have cholesterol values between 270 and 299 mg/100 ml and the proportion of the females is 17.8 percent for the same values. Some authorities consider this a significant elevation.

In the under 35 age group, this value is found in 5.8 percent of males and only 2.4 percent in the females.

In the entire population studied, 7.9 percent of the males have cholesterol values over 300 mg/100 ml, which is considered pathological. Of the females, 9.4 percent have elevated values of 300 mg/100 ml and over. The distribution of the cholesterol values is skewed to high ranges, explaining the differences between the mean and median values observed.

In this study, about 15 percent of the males and 20 percent of the females were diagnosed as having cardiovascular disease, which explains the high frequency of elevated cholesterol values in the older age group.

Calcium, Phosphorus

Medical conditions causing deviation of calcium or phosphorus are very rare. The distribution of values is normal. Age and sex does not affect the results of tests.

Bilirubin

The average values found in our program are somewhat lower than those in published data. Biliru-

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TABLE 1—*Multiphasic case finding program; ranges* of values by age and sex—percentiles; Wisconsin, 1968–1970*

Blood Chemistry		Male <35	Male 45-54	Male 65+	Male Total	Female <35	Female 45-54	Female 65+	Female Total
Cholesterol mg%	(L)	140	154	153	150	137	150	155	148
	(M)	209	235	228	230	193	230	249	229
	(H)	307	342	327	334	285	338	359	342
Calcium mg%	(L)	9.2	9.0	8.9	9.0	9.0	9.0	9.0	9.0
	(M)	10.2	9.9	9.8	9.9	9.9	9.9	9.9	9.9
	(H)	11.4	11.0	10.8	11.0	10.9	10.9	11.0	10.9
Inorganic phosphate mg%	(L)	2.5	2.4	2.3	2.4	2.4	2.5	2.6	2.5
	(M)	3.7	3.6	3.3	3.5	3.6	3.6	3.6	3.6
	(H)	4.8	4.7	4.5	4.7	4.8	4.8	4.7	4.7
Total bilirubin mg%	(L)	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1
	(M)	0.5	0.4	0.4	0.4	0.4	0.3	0.3	0.3
	(H)	1.5	1.1	1.1	1.2	1.0	0.8	0.8	0.9
Albumin gm%	(L)	4.1	3.8	3.6	3.8	3.6	3.7	3.6	3.7
	(M)	4.9	4.5	4.3	4.5	4.5	4.4	4.3	4.4
	(H)	5.8	5.4	5.2	5.5	5.4	5.2	5.1	5.3
Total protein gm%	(L)	6.8	6.5	6.4	6.4	6.5	6.4	6.4	6.4
	(M)	7.6	7.3	7.2	7.3	7.4	7.2	7.2	7.3
	(H)	8.6	8.2	8.2	8.3	8.4	8.2	8.1	8.2
Uric acid mg%	(L)	4.0	3.7	3.6	3.7	2.7	2.9	3.0	2.8
	(M)	6.0	5.9	5.9	5.9	4.2	4.6	5.1	4.6
	(H)	8.9	8.9	9.4	9.1	6.4	7.3	8.5	7.6
Blood urea nitrogen mg%	(L)	9	9	10	9	6	8	10	8
	(M)	14	16	18	16	11	14	17	14
	(H)	22	24	29	25	18	22	27	24
Glucose mg%	(L)	53	60	70	60	51	64	72	61
	(M)	88	102	111	100	86	102	112	102
	(H)	136	182	230	186	132	174	224	185
Alkaline phosphatase KAU	(L)	32	34	35	33	25	27	36	27
	(M)	58	60	63	60	45	53	65	55
	(H)	105	110	135	113	90	105	125	110
Serum glutamic oxalocetic transaminase KU	(L)	10	11	9	10	7	7	9	7
	(M)	25	25	24	25	20	21	23	21
	(H)	54	55	48	54	39	45	42	43

* (L) Low—2.5 percentile; (M) Median; (H) High—97.5 percentile

bin is sensitive to light, and in the early part of this program no attempt was made to protect the specimens from light exposure, causing some deterioration. In the last two years, the specimens were well protected from light and the mean values are the same as in the published literature.

Persons under 35 years of age in both sexes have higher bilirubin values than in the older age groups. In our system, females had lower bilirubin values. Males in all age groups had 4 or 5 times higher bilirubin values in the "abnormal" ranges (1.2 to 1.8 mg/100 ml and over) than females.

The higher proportion of SGOT (Serum Glutamic Oxalocetic Transaminase) values in the higher range among males may increase the index of suspicion that alcohol consumption, which is more prevalent among males, is a possible explanation for the different bilirubin values by sex. "Gilbert's syndrome" is found more often among young males than females.

Total Protein, Albumin

The statistical distribution of values in this study compared well with data published elsewhere. There is a slight decrease in total protein in the 65 and over age group, explainable by increased proportion of patients with cardiovascular and renal disease in the general population. The values for both of these components are normally distributed.

Uric Acid

The distribution values found in this test agree very well with the published literature. There is a marked difference in the values for males and females. The mean and the median values are higher for males.

The largest differences in the means is observed in the group under 35 years of age. Smaller but significant differences exist in the over 65 age group. The mean values for males is independent from age. The increase of uric acid values by age is noticeable for females.

The health questionnaire administered at the time of specimen collection reveals that 2.9 percent of males and 1.7 percent of the female participants believe that they have gout. Five and two-tenths percent of the male population and 9.6 percent of the female population are using medication for blood pressure.

The proportion of users of diuretics increases by age and it is known that these drugs have a tendency to raise the uric acid levels. This may partially explain the increasing values of the variance by age groups.

Blood Urea Nitrogen

The methodology in this determination is reliable and our data is in close agreement with published results. The mean values as well as the variance increase by age.

This is not a very sensitive test to discover kidney failure. In the age group 65 and older two percent of the male population had values of larger than 30 milligram percent as compared with 1.2 percent of the females. This may be explained by the higher frequency of obstructive urinary tract disease among the males.

Glucose

Values obtained in our study differ from those published in the literature because our population received a loading meal of 75 gm carbohydrate or more. There is a marked increase of mean values by age for both sexes. No sex differences were observed in the mean values.

Six and three-tenths percent of the males and 5.5 percent of the females had blood sugar values over 160 mg/100 ml. Generally the prevalence of diabetes is higher among females.

In our study 3.7 percent of the males and 2.4 percent of the females stated that they were diagnosed diabetic. This is a lower prevalence rate among females as observed in other epidemiological studies. A possible explanation is that diabetics generally are receiving frequent blood sugar determinations and they feel less need for blood tests in the screening program. The sex differences of prevalence may be caused by more frequent medical examination of females than males in general, resulting in more females having blood sugar determinations.

Alkaline Phosphatase

There is a slight increase of median values by increase in age. The females had somewhat lower mean values. Again agreement with published literature was noted.

SGOT (Serum Glutamic Oxalocetic Transaminase)

The mean values for males are independent of age whereas there is a slight increase by age groups in the females. Two and four-tenths percent of the males and 1.0 percent of the females had values of larger than 55 international units. The effect of alcohol consumption and prevalence of "Gilbert's syndrome" was previously noted above in the paragraph dealing with bilirubin values. □

New Glaucoma-treatment Method

A new glaucoma-treatment method, which relies principally on the drug, protriptyline, has been developed and patented by Dr. M. D. Langham, a Johns Hopkins ophthalmologist. He assigned the patent to the Dept. of Health, Education, and Welfare. □

What Kills Wisconsin Children?

The Physician's Responsibility in Accident Prevention

ELAINE KOHLER, MD, Milwaukee, Wisconsin

Are Accidents the Physician's Business?

ACCIDENTS ARE THE MAJOR cause of death from one to 35 years of age. In childhood, beyond the first year, not only are they the most common cause of death but also they cause more deaths than the next ten causes combined. Even in the first year they are the fourth largest cause of death after immaturity, congenital defects, and respiratory problems.[1]

Physicians have traditionally involved themselves little in the prevention of accidents, partly because in many fatal accidents the patient dies within one hour—before medical attention can reach him. Also, accidents are generally accepted to be "acts of God" not subject to mortal intervention. To put this view in perspective, it should be remembered that most diseases were once seen in that light. It is against our training and belief in the effectiveness of medicine to accept a major cause of death as impervious to our efforts.[2]

Particularly in the field of pediatrics, the tradition of preventive medicine is strong. Much morbidity and mortality are avoided because of public health measures and immunization programs. Furthermore our treatment of illness is frequently preventive in that it is designed to avert more serious complications of the disorder treated. The question arises whether accidents can also be prevented.

We should derive encouragement from the success which has been seen in one area of accident prevention—accidental poisoning. Since interest was generated among physicians about twenty years ago in poison prevention, a significant decrease in poison deaths has been seen—over 25% nationally.[3] The measures taken were: widespread publicity regarding hazards, the establishment of poison control centers throughout the country to bring immediate information to the victims of poisoning, and pressure on manufacturers and legislators to enact protective measures. Can similar methods be applied to the problem of accidents in general?

One of the arguments against physician involvement is that medical training is not necessary for programs of accident prevention and there is a shortage of physicians available to do the task for which they are trained. The obvious counter-argument is the "ounce of prevention . . ." The major reason for physicians becoming involved is the credibility of the physician when talking about what is good for people's health. The doctor is the person who is supposed to know how to keep people well and alive.

The Experience with Poison Control

Let us look at what was done with poisoning. First and foremost—educational efforts were directed at physicians, hospital personnel and laymen, simply by talking individually and publicly, so that the hazards of common household poisons would become known. Secondly, poison control centers were established with files on poisonous substances and regional telephone services to answer the questions of doctors and of the public concerning ingestions. At the National Clearinghouse for Poison Control Centers, experience with individual ingestions from regional centers is added to information collected from manufacturers and fed into a computerized data center which organizes the material. Data thus accumulated is sent to the individual centers for their files. And third, legislation has been effected in a Federal Labeling Act for most household products which could be harmful. More recently a bill has been passed making it legally necessary to place all toxic substances in childproof bottles.

Pressure was also exerted to accomplish some changes voluntarily, such as getting poisonous fluid extract of ipecac out of the pharmacies to avoid confusion with syrup of ipecac which is a useful emetic in childhood poisonings, and limiting the content of aspirin bottles to 25 or less so that the ingestion of the whole bottle would probably not be lethal to a child. The active forces in executing these measures were the National Association of Poison Control Centers and the American Academy of Pediatrics—Subcommittee on Accidental Poisoning, both of which are composed largely of MDs.[3] So, doctors have influenced the incidence of at least one form of accident.

Automobile Accidents

What are the major killers of Wisconsin children today? As in other age groups, the automobile is the leader. It is the most "passive" accident in which

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the child is involved. In the automobile the child under licensing age seldom contributes to the occurrence of the accident. In the larger number of automobile accidents, children are involved as passengers, not pedestrians. Every year in Wisconsin about 100 children under age 15 are killed in automobile accidents, and the number is steadily increasing.[4]

As in adults, the major safety recommendation is for seat restraints. The best way to protect children is to put them in the back seat with a solid infant seat for the smaller child, or a child restraint for the older child. Ford has put out a sturdy child safety shield, and General Motors has made a sturdy infant seat with a padded handrail. The habitual use of such restraints could markedly improve our accident fatality statistics for children. When people are unwilling to get involved in these more effective measures, a simple seat belt will improve chances of survival. The most important thing that parents can do in this regard is to set an example for their children.[5]

In areas where the government has been courageous enough to pass effective legislation, such as the Scandinavian automatic jail sentence for drunken driving, or the automatic revocation of license for speeding in some states, a marked decrease in fatality statistics has been seen. If such measures seem harsh, one has only to think of the magnitude of the problem. The killing of 50,000 people a year in automobile accidents in this country is equivalent to slaughtering the entire population of a city the size of Wauwatosa, Sheboygan, or Appleton annually.

Pedestrian accidents are a significant part of the childhood automobile fatalities. A simple effective means of improving pedestrian statistics is the use of reflectorized clothing or tags, such as are being used in Scandinavia.[6] An effective program in Milwaukee has been the use of patrol men and women to help children across the street going to and from school. These people not only protect the children at the hour of greatest danger but also educate children in safe pedestrian behavior.

Drowning

The second greatest cause of accidental death for Wisconsin children is drowning.[4] The recent increase in home swimming pools is considered a large factor, but in our state, lakes are a frequent hazard. Physicians should support swimming programs in their community, especially basic lessons in learning to float and swim. If the programs are overcrowded, then preference should be given to children who do not know how to swim at all. Older children should be encouraged to learn life-saving and resuscitation, as a physician is seldom able to reach the scene on time.

Pools and ponds should be fenced in. Physicians should support their communities' placing signs on frozen lakes when they begin to thaw, warning the population of dangerous ice. Finally, as in all accidents, supervision of young children playing near water and older children in water sports is important.[7]

Suffocation

The suffocation of infants may be a questionable statistic, as inexplicable infant deaths are sometimes put into this category. Statistics show about 30 infants a year die of suffocation in our state.[4] If aspiration is included, the figures rise to about 40 a year. Today everything comes in plastic bags, and plastic bags are a major hazard. Particular attention should be paid to the dangers of filmy plastic, such as is used to cover clothes, but clear plastic food wrappers, zippered bags, and plastic pillows are all potential hazards. Bell harnesses are another danger, as children get tangled in them. A firm mattress and a loose cover are safest for the very small infant.

The question of toy safety is currently under legislative consideration. A number of toys have been demonstrated to have small detachable parts which children can aspirate.

Fire

The fourth largest killer of children in our state is fire. More than 25 children a year are killed by fires.[4] The old cliché about children playing with matches still holds, as it is a major source of fires which injure children. Other fires start in the kitchen when ovens and burners are left on. Solvents left near open furnaces in the basement are also a hazard. A study done by students at the Medical College of Wisconsin showed that many scalding, disfiguring burns could be avoided by the simple expedient of cooking on the back burner instead of front burner when there is a toddler in the house.[8]

Legislative efforts are underway to require fabrics to be less flammable. With the exception of rayon, cotton is even more flammable than the synthetics, while wool and silk are relatively inflammable. All fabrics can and should be treated to be made flame resistant. There is already a Flammable Fabrics Act against explosively flammable fabrics since an incident in the 1950s when many children were severely burned by highly flammable chaps.[9] The pending legislation deserves our support.

A factor in morbidity from burns is that first aid knowledge about treating fresh burns is still largely ignored in favor of harmful home remedies. Many people will put butter, grease or powder, and fre-

quently some fabric, on a burn. It has been suggested that Saran Wrap makes a non-adhesive, relatively sterile dressing which can be used to protect a burn on the way to the Emergency Room.[8] Knowledge about first aid treatment for burns could be posted in physicians' offices to avoid such maltreatment.

Other Fatal Accidents

In fifth place now, after automobiles, water, fire, and suffocation, there are a number of types of accidents, each of which kills about ten Wisconsin children a year. Accidental poisonings still do. Firearms kill that many every year, mainly boys aged 10 to 14. As in the case of drowning, gun safety rules and programs are effective in diminishing these accidents.

Falls are another major cause of fatal accidents in children. In the second half of the first year, infants generally fall off a dressing table, crib, or other piece of furniture where they have been placed by their mothers. This is one area of accident prevention which doctors and their office personnel automatically undertake. When we see a mother leave her baby unattended on the table, we usually give a lecture on avoiding falls. Mothers might also be warned that, in addition to having side rails on the crib, large toys which may be used as stepping stones should be avoided, and a thick rug will help cushion any fall which occurs in the baby's room.[10] For the toddler windows, stairs, and porches should have guards. Among older children, falls frequently occur from barns or machinery on farms with serious consequences.

Machinery is another cause of significant morbidity and mortality in our state. The snowmobile is a new hazard often regarded as a toy rather than as a potentially lethal vehicle. The tremendous speed and lack of safety equipment, combined with the lack of regulations regarding the age of the operator, has made them a source of many accidents in recent years. About seven children a year are killed in tractor accidents. Older children turn them over while they are driving, and younger children fall off of them.[11]

The Physician's Role

This then is the problem for Wisconsin children. Given the common causes of accidents and suggestions for preventing them, what can physicians do? As in the case of poisoning, education is probably the most important factor. Pressure on manufacturers to avoid some of the dangers intrinsic in products can be exerted both by organized medicine and by education of the consumer. Ultimately, legislation will be needed, particularly in the realm of automobile and machine accidents. As physicians, we should support all such legislation individually and through our organizations.

The question arises whether something like Poison Control Centers is needed for managing accidents. The hospital emergency room has traditionally been the center for handling accidents. However, it has been suggested that, given the same accident, a soldier on active duty has a better chance of survival than a civilian in one of our own cities. Transportation facilities for accident victims are better there and the injured are immediately funneled to an appropriate center for the care of their particular emergency.

Setting up efficient means of responding to accidents, by air if necessary, and having more effective ambulances with trained attendants is a major step which could be taken. Many ambulances available at the present time are manufactured more for the specifications of hearses than living patients. Other designs for ambulances have been described, but vehicles in which a medical attendant cannot stand up to administer care predominate, encouraged by the fact that many attendants are not trained to give care.[12] The hospital emergency room is logically the center for handling accidents. The organization of emergency facilities into specialty centers, such as burn centers and trauma centers, is a useful emerging trend.

If accidents are studied as other sorts of diseases have been, with efforts directed to understanding their pathogenesis, then preventive measures can be undertaken. With the implementation of such measures, we might some day be able to diminish our accident statistics so that we may look back on the accident tolls we take for granted today as the dark ages of childhood accidents.

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Emergency Treatment of Narcotic Overdose

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

LESS THAN TEN YEARS AGO, drug abuse was confined essentially to the lower socio-economic levels of the urban cities. In the last few years, however, it has infiltrated to the affluent suburbs. In spite of the recent massive effort to control drug abuse, the incidence and gravity of its seriousness are continuously unabated.

In a large city such as New York City narcotic overdose, particularly heroin, has become the leading cause of death between the ages of 15 and 35. The frequency of overdose due to methadone appears to be closely related to the establishment of methadone maintenance programs in the country.

Because of the lack of emphasis in the past on the proper approach to the management of narcotic overdose, many hospitals, clinics and physicians' offices need such medical information. For this reason, pertinent comments on this subject are apropos.

In detecting overdose of narcotics, the medical history from the patient (if he is able to communicate) or from a friend or relative is most important. If the patient is comatose, pinpoint pupils and depressed vital signs will give strong clues of narcotic overdose. However, respiration may present in different forms varying from apnea, shallow respiration, orthopnea, tachypnea, or dyspnea. Other positive evidence is recent or fresh needle marks along the veins of the arms and hands particularly the antecubital veins. At times, medications or containers found with the patient or in his surroundings give additional clues to the type of drug used.

When the overdose has progressed to a later stage, cyanosis, areflexia, hypotension, and cold clammy

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pallor may be seen. Thus, the most life-threatening situation of narcotic overdose is marked respiratory depression, circulatory collapse, or both.

Another frequent result or complication of opiate overdose is the development of pulmonary edema. This entity was first described by Osler in 1880. The manifestations of pulmonary edema due to opiate overdose may vary from the total absence of symptoms to marked dyspnea and hypotension. Râles are usually heard in the lungs without evidence of neck vein distension or cardiomegaly. The chest x-ray film will reveal marked pulmonary congestion. Attempts to determine the mechanism of the edema have so far been unsuccessful.

Studies using opiates to reproduce the pulmonary edema in monkeys by simulating all the clinical settings which precipitated the development of edema in humans have failed. The occurrence of pulmonary edema may not be directly related to the overdose of opiates. Recent reports by Pierson, et al, *JAMA* 220:1733, 1972) showed the "sudden infant death syndrome" in which unexpected death occurred in infants whose mothers received methadone during their pregnancies. There was no evidence of ingestion of opiates by the children. The only abnormal finding at autopsy was marked pulmonary congestion.

Meperidine (Demerol®) overdose presents a picture quite opposite to that of overdose of morphine and its congener. The patient may develop tremors, muscle twitches, dilated pupils, hyperactive reflexes, and convulsions.

TREATMENT

The treatment consists of two parts: (1) supportive therapy and (2) use of narcotic antagonists.

Supportive Therapy

Any patient with a diagnosis of possible opiate overdose should have immediate and proper care. The first measure is to provide a patent airway. This includes suction of the mouth, nose and oropharynx to remove vomitus, mucus, blood, and other materials which obstruct the air passages. If the patient is not breathing, mouth-to-mouth or mouth-to-nose resuscitation should be done. It is ideal to use an Ambu bag which is usually available in an emergency room. Endotracheal intubation may be performed if a qualified physician is available.

The respiratory center is depressed by narcotic drugs. Thus, the accumulation of carbon dioxide which normally stimulates the respiratory center will not be effective. Hypoxia is the only mechanism left to stimulate the chemoreceptors to increase respiratory activity. Oxygen alone will further depress the respiration. For this reason, oxygen, if given, should then be administered through assisted ventilation.

While maintaining adequate respiration, the circulatory system should also be assessed for the presence of an adequate pulse and blood pressure. If no heart beat is detectable, external cardiac massage should be started following the routine procedure for cardiac arrest.

As in any cardiac resuscitation, appropriate measures should be followed to save the life of the patient. Metaraminol (Aramine®) or norepinephrine (Levophed®) should be given with a parenteral solution to maintain an adequate blood pressure. After establishing adequate respiratory and circulatory functions, chest x-ray film, electrocardiogram, arterial blood gasses and identification of chemicals in the blood and urine should be done.

It is not uncommon to find respiratory or metabolic acidosis after opiate overdose. This may require the intravenous use of sodium bicarbonate until an adequate arterial blood pH is obtained. A Foley catheter should be inserted to assess adequacy of urine output.

Pulmonary edema due to opiate overdose usually responds to adequate ventilation by the use of intermittent positive pressure or a fixed volume respirator at 100% oxygen. The intravenous use of a potent diuretic such as furosemide (Lasix®) or ethacrynic acid (Edecrin®) may help relieve the congestion. Unlike the pulmonary edema of organic heart disease, digitalis, diuretics, phlebotomy, and other procedures have been used only on an empirical basis.

Use of Narcotic Antagonists

The most specific method of treatment of narcotic overdose is the use of narcotic antagonists. There are three narcotic antagonists available at present as antidotes for opiate overdose: (1) naloxone [Narcan®], (2) nalorphine hydrochloride [Nalline®], and (3) levallorphan tartrate [Lorfan®].

Naloxone (Narcan®). The drug of choice in narcotic overdose is naloxone. It is the N-allyl derivative of oxymorphone with virtually no agonistic (morphine-like) effects. It is a safe potent narcotic antagonist available at present in 10 ml vials at a concentration of 0.4 mg/ml. Safe and effective use in children has not been established. It is short acting and so far has not been found to produce any untoward side effects such as respiratory depression even in high doses. It should be given immediately to comatose patients possibly resulting from narcotic overdose. The initial dose of naloxone is 0.4 mg intravenously. If a patient is still unresponsive after 5 minutes, a second dose of 0.8 mg should be given. If no response is obtained after the second dose, the respiratory depression is not likely due to narcotic overdose. When a beneficial response is obtained, naloxone may be given intramuscularly or subcutaneously every 1 to 2 hours, if respiratory depression persists.

Repeated administration of naloxone is due to its short duration of action at that dose level. It has not been shown to have any deleterious effect, if given to patients with respiratory arrest due to other depressant drugs. Because of the dramatic therapeutic value of naloxone in the treatment of narcotic over-

dose, it should be made readily available in all emergency rooms and in all emergency carts. It is necessary to determine the self-administered drug which the patient ingested and its route of administration. Gastric lavage may be done, if the drug is taken orally within 4 hours after ingestion.

Methadone has a long duration of action; therefore, overdose due to methadone produces prolonged respiratory depression. Closer supervision and management of the patient is needed in order to watch for recurrent respiratory depression after the effect of the antagonist disappears. Since most methadone overdoses occur through ingestion of the drug, gastric lavage may be able to recover part of the drug.

Nalorphine hydrochloride (Nalline®). In the absence of naloxone, nalorphine may be used as a substitute antidote. It is available in 1 ml ampules at a concentration of 0.2 mg/ml in 1 and 2 ml ampules and 10 ml vials at a concentration of 5 mg/ml. A dose of 5 mg intravenously should be given. If no improvement in respiration is seen, the dose may be repeated in 5 minutes. If no response is obtained after the second dose, the respiratory depression is not due to a narcotic. In the case of an infant, 0.1 to 0.2 mg may be given.

Nalorphine hydrochloride has been used extensively in the past as an antidote for narcotic overdose. However, it has the disadvantage of having morphine-like effects such as respiratory depression. It could aggravate the respiratory depression produced by other depressants such as barbiturates. Although it also possesses analgesic activity, it produces the untoward side effects of hallucinations and other psychotomimetic effects.

Levallorphan tartrate (Lorfan®). In the absence of naloxone, Lorfan® may also be used as a substitute antidote. It is available in 10 ml vials at a concentration of 1 mg/ml. The dose is 0.5 to 1.5 mg intravenously. If no response is seen after 5 minutes, the dose may be repeated. Absence of response indicates that the respiratory depression is not due to opiate overdose. A dose of 0.05 to 0.1 mg may be used in the case of an infant. Lorfan® produces similar untoward side effects as nalorphine, and both drugs have fallen into disfavor in their use for narcotic overdose.

Narcotic antagonists have been effectively used to decrease neonatal respiratory depression secondary to the administration of narcotics to the mother. When used for this purpose, the antagonist may be given either to the mother shortly before delivery (preferable) or to the infant by way of the umbilical vein following delivery. Narcotic antagonists cannot be expected to decrease apnea of the newborn caused by trauma of delivery or other factors. They are not effective antagonists against drugs other than narcotics.

If unresponsive to any of the narcotic antagonists used, supportive therapy to maintain adequate respiratory and circulatory function should be continued until the cause is determined. It is necessary to have positive evidence of chemicals in the blood and urine not only to confirm the diagnosis but also for proper management and for medicolegal reasons.

The next most frequent drugs that cause respiratory arrest are the barbiturates. The treatment of barbiturate overdose with respiratory arrests consists of similar supportive therapy to maintain adequate respiratory and circulatory functions. Gastric lavage is usually avoided to prevent aspiration pneumonia. Adequate fluid and electrolyte therapy is necessary until the patient regains consciousness.

Withdrawal symptoms may appear with the use of antagonists in patients dependent on narcotics such as nervousness, retching, and goose flesh. The pupil will rapidly change from constriction to dilatation. Vomiting may occur when the patient starts to respond to the antagonist. Thus, emesis basin should be made available. Other withdrawal symptoms may also appear. Death from withdrawal of opiates per se does not occur, but withdrawal symptoms could be quite uncomfortable. Small doses of morphine may be used parenterally to combat severe withdrawal symptoms. If the overdose is due to meperidine, the narcotic antagonist will counteract its depressant effect, but not the excitatory effect. If convulsions occur with meperidine overdose, phenobarbital 100 to 200 mg may be used to control the convulsions. □

NASA Technology As An Aid to Cities

At a recent conference in San Francisco representatives of American cities and other subdivisions of government, considered ways of using existing new technology in solving municipal and urban problems. Of interest to physicians was a comprehensive exhibit of medical aids including an audiometric (EEG) helmet for identifying deafness in children; a psychomotor response tester for use in traffic departments and educational institutions; plus various advanced devices for checking blood circulation electrocardiograph readings and circulation in human patients. The conference seminars and working groups "concentrated on the problem of closing the gap between making technology available and applying it successfully in the market we all know exists," stated Dr. Jerry Grey, administrator of Technical Activities for the American Institute of Aeronautics and Astronautics. □

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LEARNING DISABILITY

A Cooperative Team Approach

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THE AREA OF LEARNING DISABILITY has become a very popular one over the recent years and many fields are now involved in diagnosis and remediation.[1-9] Nonetheless, the number of children referred to our Pediatric Neurology Clinic for learning problems has seemed to be a continual one and has proved to be a ready source for study and evaluation.

We have attempted to correlate some of the various interests and specialties that have been concerned with the problems of learning and combine them into a group designed to deal with an individual child. The core group included a neuropsychologist, a social worker, an occupational therapist, a speech pathologist, an educator, and a pediatric neurologist. A psychiatrist, an ophthalmologist, and an otolaryngologist have played important roles in assisting the group.

Methods

Fifty children referred to the Learning Disability Group of the University of Wisconsin Medical Center were admitted to this study. All were failing to achieve the level of academic success expected of them. The children were seen by each member of the group (neuropsychologist, social worker, occupational therapist, speech pathologist, educator, and pediatric neurologist) and testing done. The battery of examinations varied somewhat for each child, but all took the Weschler Intelligence Scale for Children (WISC). Each member of the team had an assigned goal. The occupational therapist was to define the motor skills and the child's abilities in the activities

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of daily living. The social worker was to gain information as to the emotional stability of the family and provide a liaison between the Group and the school. The speech pathologist had the goal of determining the child's speech and language abilities. The neuropsychologist worked to find the level of school achievement, the level of his mental functioning, and areas of strength and weakness. The pediatric neurologist worked as the coordinator of the team and the determinator of medical health and of neurological impairments. The role of the educator was to help formulate the proper remedial program. An electroencephalogram, skull x-ray films, hematological and urine studies were also done on each child.

The patients were generated by referral from various sources in Wisconsin, Northern Illinois, and Eastern Iowa. The school (principal, teacher, psychologist, and school nurse), county (nurse, social worker and psychologist), and the child's physician have been the chief sources of referral.

An ophthalmologist, otolaryngologist, and psychiatrist have seen the child at the discretion of the Group. Other disciplines of the Medical Center have become involved with the care of a child if indicated.

Results

Of the 50 children in this evaluation, 39 were boys and 11 were girls. The ages ranged from 7 to 14 years with a mean of 9.9 years. The boys ranged from 7 to 13 years with the mean being 10 years. The range for the girls was 7 to 14 years with the mean being 9.5 years.

The Weschler Intelligence Scale for Children scores had a mean of 102 for the group with the range of 85 to 124. The girls showed a range of 88 to 108 with the mean of 97. The boys ranged from 85 to 124 with the mean of 104. The subtest scores on the WISC and the results of speech and occupational therapy tests are not presented at this time, as no correlations could be drawn.

In the neurological evaluation, 31 (62%) showed significant findings in their examination. Twenty-eight (56%) were of the "soft" type with difficulty with rapid alternating movements, right-left discrimination problems, tremor, and/or variable parietal lobe signs. Hyperactivity was noted in 8 (16%) of the children. Two (4%) had significant auditory impairment with a partial hearing loss. One child (2%) was found to have spastic diplegia.

Ocular problems were noted in 2 children (4%), these being myopia and/or astigmatism of a significant degree to cause visual difficulty.

Emotional problems were a prominent part of the learning problem in 14 (28%). The most frequent pattern was that of aggressive behavior in 6 boys in the 12 to 13 age range. Family disruption by divorce or death was noted in 4 children (8%). Two children (4%) were having difficulties in school because of apparent mental difficulties in their parents.

The hematologic and urine evaluations were all normal. The electroencephalograms were mildly abnormal in 16 (32%). Eleven of these were boys and 5 were girls. The 2 children with seizure disorders had mildly abnormal records with a generalized increase in the theta wave activity. No focal slowing or epileptiform activity was observed in any of the electroencephalograms. Skull x-ray films were normal in all children.

Fourteen (28%) of the group were on medications, 5 (10%) on methylphenidate, 3 (6%) on dextro-amphetamine, 2 (4%) on imipramine, phenobarbital in 2, (one also on diphenylhydantoin), and ergotamine in one (2%). The 2 children on phenobarbital (and diphenylhydantoin) had had seizures. The imipramine was begun for nocturnal enuresis in both cases and the ergotamine was utilized for vascular headaches. The methylphenidate and dextro-amphetamine were being prescribed for hyperactivity.

The etiology of the learning problem was not clearly obtained in many of the children. Areas of suspect could be outlined in some; 2 boys were second twins, and one girl was a premature infant (birth weight below 5 lb 8 oz). Illness requiring frequent prolonged hospitalizations was presumed to play a role in 2 children; one had had tuberculosis and another had orthopedic difficulties. Probably the clearest etiology was seen in one girl who had been given no formal education. Genetic factors were pointed to in 2 boys who had fathers with significant reading problems. No deprivation was elicited in this group of 50 children. Overall, only 8 children (16%) had a factor that could be suspected as playing a role in the etiology of the learning difficulty.

Discussion

The diverse sources of referral with essentially the same complaint, failure to attain the expected level of academic success, has resulted in a surprisingly homogeneous group of children. The age range has fallen within a seven-year spread, the IQ within the normal range, and the boy:girl ratio within that expected for learning problems.[1,10] It would appear that such a sample was a representative one for this area and this school population. It is undoubtedly a reflection of the time when schools become concerned about the achievement of the children,

namely around the age of 9.9 years or in third grade. While a tenuous point, the transition from the learning pattern of the primary to the intermediate years may be the critical point in their school career. Because of the age range of the group and varying programs in each school system, such a hypothesis can only be suggested.

Of further interest was the failure to find an etiology in more than 16% of our population. The second born twins may have had difficulties at birth, the one premature would have been a candidate for respiratory and metabolic problems in the newborn period, but these cases are only speculations as no difficulties were observed by the attending physicians at the time of their births. The 3 children to whom school work was not given because of illness or "free school" (where academic skills are not emphasized) could be easily explained as having learning difficulties because of a simple lack of schooling. The genetic role in our cases is not clearly delineated; however, two fathers of children with reading problems reported difficulties with reading in school which have continued to the present. This aspect of a familial history is far below that pointed to by Silver.[10]

The findings of soft neurologic signs in 62% of our group appears to be of interest in that children with learning difficulties show signs of neurologic impairment. Hertzig, Bartner, and Birch[5] have observed the relatively high frequency of neurologic signs in children with educational problems; however, our children had IQs within the normal range. The abnormal electroencephalograms and the neurologic examinations have pointed to the central nervous system but the etiology and direction of treatment have not been clearly discernible from these two examinations.

Medication for hyperactivity has proved to be of some use in those children where it has been elected to be tried. We have attempted to be very selective and somewhat restrictive in the use of dextro-amphetamine and methylphenidate, and have insisted on close medical follow-up either at the Medical Center or by the child's physician.

Emotional difficulties were noted in 28% of our population. This would be within the range observed by Kappelman, Luck and Ganter.[11] The boys in the 12 to 13 year age range, with aggressive tendencies, and a recent divorce or death of a parent were particularly difficult to remediate. Five of the 14 children with emotional difficulties have shown a remarkable improvement in their attitude toward school and at home as their grades began to improve. We have assumed that this may be partly due to the increased interest of the school with a good teacher and a good program, and also due to a generalized lessening of tension at home.

The Group did not stress the diagnosis of each child, but has preferred to emphasize a means of treatment, the prescription. We have turned in this direction because the problem that the school and the family want answered is: what do we do now, not what is it or what caused it. Further impetus to focus upon the treatment aspect of the problem has been the changes that have been occurring in our schools. The fiscal restrictions being felt in many communities have markedly reduced the funds available for special learning disability programs and remedial personnel.

To meet this challenge our Group has become eclectic, using all approaches and modes of treatment. The many programs available have allowed us to pick parts of one to fit with a specific aspect of another in order to fit the needs of the child and the programs and personnel available at the school. The increasing number of combinations available has required each member to maintain a current knowledge of the progress in his field, and be versatile enough to meld with the ideas of the other team members. In the course of developing a program, the emphasis has been on a close cooperation with the child's school. Without a good working relationship between school and the Group, the development of a useful and workable program became difficult. Flexibility in approach with close and continued follow-up has been our interpretation of "eclectic."

The concept of a team approach to the problem of learning disability is not new[6,12] but has been useful for us as the Learning Disability Group at the University of Wisconsin. The combination of interests and approaches has tended to modify any single discipline's bias in diagnosis and treatment. As a team facing the fiscal situation of the schools and multiple programs for treatment, eclecticism has taken root and grown.

The question as to the success of the program cannot be clearly answered. However, we are encouraged by the improvement that has been seen in 21 of 32 children seen in follow-up. Testing at this early stage seemed to indicate significant improvement in this small number. Longer follow-up will be required before any statement can be made about the total population of 50. As a Group with an eclectic approach, we do feel we are meeting the needs of the child with a learning problem, providing guidance to the schools, and answering many of the questions of the parents.

Summary

Fifty children were evaluated by the Learning Disability Group at the University of Wisconsin Medical Center because of their failure to achieve their expected level of academic success. Each member of the team (social worker, occupational therapist, speech pathologist, neuropsychologist, educator, and pediatric neurologist) evaluated and together formulated a prescriptive program for each child. The population consisted of 39 boys and 11 girls with an age range of 7 to 14 years, Weschler Intelligence Scale for Children (WISC) scores were

A Conference on Child Abuse

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THE KNOTTY PROBLEMS of detecting, aiding, and prosecuting the adult who abuses a child were the subjects of a recent discussion on "The Abused Child." Grappling with these problems: Professor Margo Melli of the University of Wisconsin–Madison Law School, Dr. Kenneth Reeb, Assistant Professor of Pediatrics in the Medical School, Mr. Max Wald, Social Worker and Consultant for the Department of Health and Social Services, and Dr. Richard Wesenberg, Assistant Professor of Radiology, Pediatric Radiologist at St. Marys Hospital Medical Center, Madison, Wisconsin.

All of the discussants agreed that the problem of deciding when a fracture, severe trauma or bruising, malnutrition, and failure to thrive were the result of deliberate injury or chronic neglect of a child by his parents was a particularly difficult one. Doctor Reeb suggested that part of this difficulty was the result of deliberate deception by the abusing individual plus a reluctance to report a suspected incident due to the doctor's often misguided inclination to give the parents the benefit of the doubt. Mr. Wald indicated, further, that our society is of two minds about the parents' "rights" vis-a-vis their children. On the one hand we tend to believe that parents are incapable of causing malicious suffering to a helpless child, and not only physicians but also social agencies are predisposed to believe fabricated tales of "accidents" meant to disguise abuse. On the other hand, there exists an implied societal sanction of parental acts that are supposed to be "disciplinary." Children are too often presumed to be the parents' exclusive property. Mrs. Melli pointed out that even judges may be "hoodwinked" by their tendency to disbelieve tales of battery and are at times reluctant to remove children from their

An "In Depth Teaching Program" provided by the University of Wisconsin–Madison Medical School Faculty; a teaching service of the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin and cosponsored by the Madison Chapter, Wisconsin Academy of Family Physicians, and the Postgraduate Program of Merck, Sharp & Dohme.

Doctor Reeb was Assistant Professor of Pediatrics, University of Wisconsin Medical School—Madison; he is now Associate Professor of Pediatrics, Case–Western Reserve University, Cleveland, Ohio. Ms. Melli is Professor of Law, University of Wisconsin Law School—Madison. Mr. Wald is Education Agency Liaison, Wisconsin Division of Family Services; and Doctor Wesenberg is Assistant Clinical Professor of Radiology, University of Wisconsin Medical School—Madison.

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from 85 to 124. Various other findings were discussed.

The emphasis was placed on treatment in order to meet the needs of the child and the available school programs. The Group utilized all conceivable and potential modes of treatment with careful follow-up. Interdisciplinary and school cooperation were the keystones of our remediation program.

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homes on the assumption that the natural parents may be the best in spite of the accusations.

Thus, with the stickiest barrier to attacking the problem of child abuse being society's inability to conceive of its existence, it becomes necessary for those who are aware to propose ways of cracking the barrier. The discussants suggested several approaches. Doctor Reeb's approach was one which educates the physician to the etiology of abusive acts by families in an effort to prevent them or to reduce them in the future through direct medical and psychological aid to distressed families. Mr. Wald's approach emphasized the legal pathways open to physicians and other personnel which would both protect the person reporting an act of abuse and lead the abusive parent to other social agencies who would work with the physician in an attempt to eliminate future such battery. Mrs. Melli's approach described the role of the law after reportage, but cautioned against the assumption that legal action was the best mode of obtaining help for an abused child.

Doctor Reeb's "primary" or "ecological" approach contained an educative, statistical profile of the abusing family. The parents who batter their children were usually young and were married early. In one

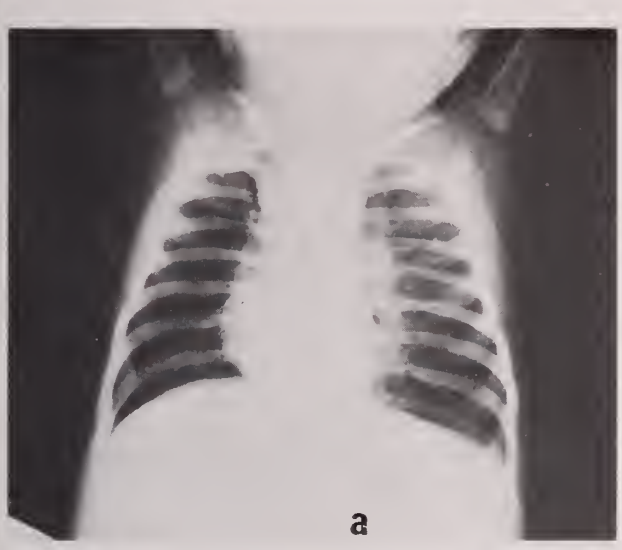


Figure 1A—Anteroposterior chest film of a 9-month-old infant with meconium peritonitis at birth and changes of cystic fibrosis of the lungs. Note the normal proximal humeri.

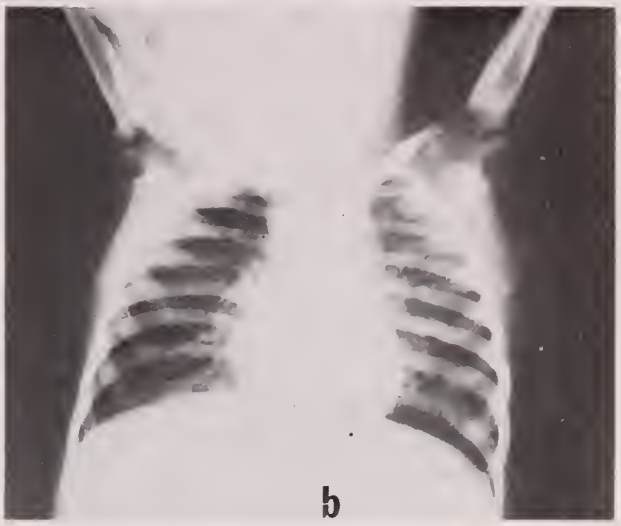


Figure 1B—Same patient at age of 18 months. There is a healing fracture of the proximal left humerus.

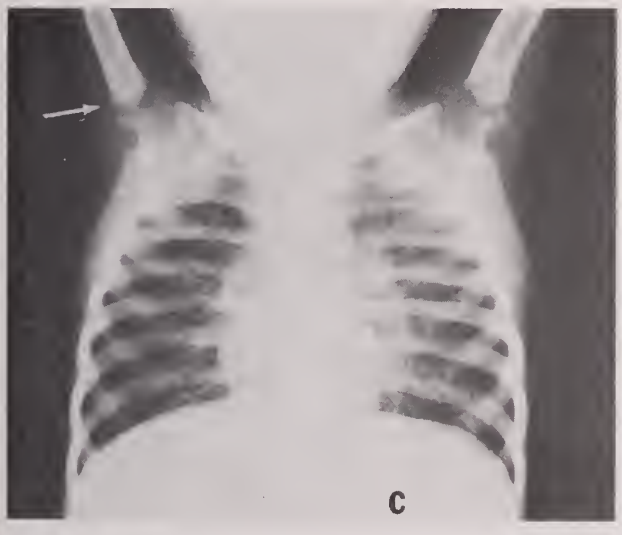


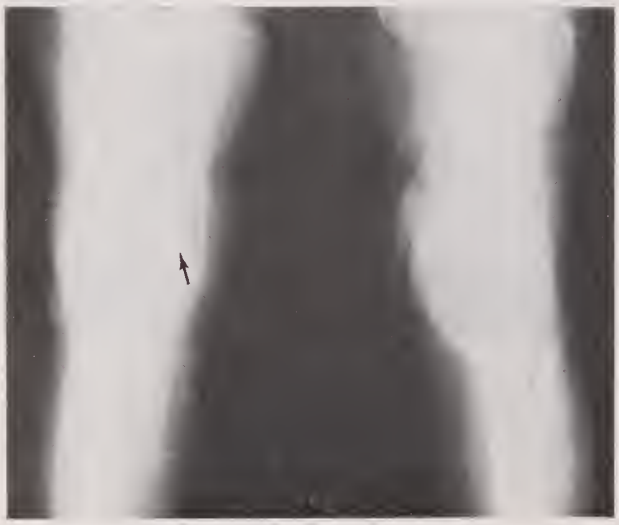
Figure 1C—Same patient at age 2 years. The left humeral fracture has healed with only mild residual cortical thickening. There is now an acute metaphyseal fracture of the proximal right humerus (arrow). Note that the general bone density is normal throughout this series of films.

Figure 1D—Same patient 9 days later. There is early callus formation present on the right. Note the slight deformity of the proximal left humerus.

study, two thirds of those who inflicted abuse were the natural parents (as opposed to babysitters or other family members). Often both fathers and mothers were guilty. Abusive parents tended to be generally hostile and anxious and to have poor impulse control. Five percent were psychotic; 10% were retarded; 35% were disturbed; and 15% drank to excess.[1] Two thirds of them had less than a high school education and most were generally incompetent as parents—domineering and rigid with inappropriate expectations for their child's development and feelings of anger toward him. The child, himself, is usually young (in many cases under a year of age). He is frequently unhealthy (30% are premature), has had severe illness in infancy, fails to thrive or is developmentally retarded.[2] He is often "uncontrollable," has frequent temper tantrums, or is either hyperactive or listless.

Environmental *stress* almost always surrounds an incident. Frequently the family is poor (although not always). Often the child is the issue of an out-of-wedlock pregnancy or is one of many children born close together whose mother is again pregnant or has recently had another baby. Their households are disorganized; there is frequently marital discord. The parents have few close friends to turn to in times of stress, have few extended family members and are socially isolated. Often both parents are unemployed.

Figure 2—Anteroposterior film of the knees at age 2 years (same patient as in Figure 1). There is moderate soft tissue edema about the right knee. A metaphyseal corner fracture of the medial aspect of the distal right femoral metaphysis is present (arrow). Multiple fractures of this type are virtually pathognomonic of the battered child syndrome. This case is a classical radiographic example of multiple fractures secondary to child abuse.



Educating the physician to the symptoms of the population at risk is one way of attacking the identification problem. Another, according to Doctor Reeb, is emphasizing the role of the physician and the health team as the pivotal link between disturbed individual families and the health, social, and legal agencies available to aid them. Physicians are not alone responsible but are part of a comprehensive structure whose members share this responsibility. By being made aware of the ecology—that is, of the entire emotional complex which surrounds the incident of child abuse as well as the social complex which exists to help him correct conditions leading to it—the physician is more likely to confront the situation realistically and to take appropriate action. Often this involves a series of steps: analyzing the specific strain which led to the occasion; reporting the case to the proper legal and social authorities; working with these agencies to prevent future acts.

Prior to any of these steps, of course, is the necessity of recognizing the problem and making a diagnosis. As Doctor Wesenberg pointed out, the radiologist is often the primary doctor's strongest ally in this, as there are radiologic patterns which specifically suggest deliberate injury. Briefly, these are (1) a fracture or fractures, the severity of which is out of proportion to the history of trauma, (2) multiple fractures in various stages of healing, (3) the presence of multiple metaphyseal corner fractures.

General bone density is normal. This is important as conditions having decreased bone density such as osteoporosis and osteomalacia (rachitiform diseases) may simulate the above patterns after mild trauma unrelated to abuse. The long bones are most commonly involved (Fig 1), followed by the ribs and skull. Compression fractures of vertebral bodies have been described. Metaphyseal corner fractures of the long bones are virtually pathognomonic of the battered child syndrome (Fig 2). Most cases have been reported in infants. The metaphysis is the only area of bone in which the periosteum is tightly fixed in the infant. With twisting and jerking of the limbs during child abuse the periosteum avulses a tiny chip off the edge of the metaphysis, the metaphyseal corner fracture. This may be a subtle finding. However, if there is even a suspicion of the finding being present, followup films are mandatory in one to two weeks. Periosteal reaction at that time will confirm the suspicion of fracture. In addition to the previously described findings, rupture of abdominal viscera with pneumoperitoneum

or hemoperitoneum may also be present. Cerebral arteriography and pneumoencephalography are required for evaluation of subdural and other cerebral hematomas and for a gross assessment of the amount of brain damage when indicated clinically.

Whenever there is even the slightest suspicion by the pediatrician or radiologist of child abuse, a complete skeletal radiographic survey should be ordered including anteroposterior projections of all four extremities. The syndrome of child abuse is to be differentiated from the syndrome of child neglect in which the radiographic findings consist of retarded bone age and mild osteoporosis. The latter syndrome is primarily a clinical diagnosis. On occasion the child may be both neglected and abused.

The correlation of such radiologic findings with other clinical evidence is usually the precipitating step in the process which may ultimately enlist the community in the child's cause.

Mr. Wald's solution included a combination of social consciousness and awareness by physician and community alike of the resources available. A step forward has been the amended 1967 Child Abuse Law in Wisconsin. This law protects the reporter from civil and criminal prosecution yet avoids the inflexibility of a prescribed list of types of abuse.

Such legislation does not prevent loopholes, however. The doctor may not be aware of repeated injuries due to the fact that parents may consult many different physicians to prevent detection. Some reporting agencies simply are ignorant of the law or have poor coordination with other agencies involved with the family and fail to detect the fact of abuse. Often the offending person moves and there is no followup. Faulty diagnoses may be entered, due, as stated above, to an inability to digest such flagrant abuses of parental rights.

Closing the loopholes may require some imagination. One suggestion: hold the child without due process on the doctor's say-so. Another: appoint a separate attorney to represent the child's interests, since the interests of parents and children may be in conflict. In actual cases of abuse severe enough to require criminal action, however, large percentages of cases are dismissed for insufficient evidence.

What communities really need, according to Mr. Wald, is not another agency dedicated to the child's welfare but agencies whose priorities include such things as (a) dedication to prompt reporting of all suspected cases, (b) adequate remedial services for suspected abusers in order to facilitate rehabilitation, (c) quick summary action by courts, (d) round the clock emergency receiving facilities for children, (e) and homemakers who can teach adequate mothering. Although Mr. Wald felt that prevention at the primary level was most difficult, prompt action after abuse occurs by committed community resource persons may prevent future excesses.

Mrs. Melli was not as optimistic about the security afforded by the legal system. If the objective is to obtain help for the child and his family, court action may be unnecessary and inappropriate. Court proceedings will focus initially on the facts of the child abuse—and not on the need of the child and his family for help. Court action should only be resorted to when cooperation of the parties cannot be achieved and with recognition of the limitations of court procedures.

If the court action sought is a criminal prosecution, it will focus on the determination of the guilt of the accused. In a criminal case, a free society such as ours places great value on protecting the accused. He is presumed innocent; his guilt must be proved beyond a reasonable doubt. The concern of the law is not with the child but with affording the defendant a just and fair determination. Persons charged with a crime are usually free on bail pending court hearing and an accused parent is frequently released to the same stressful situation which threatened the child in the first place. Persons concerned with abused children must understand that the criminal justice system always brings into play these competing considerations.

Mrs. Melli suggested that the child's interests stood the best chance in Juvenile rather than Criminal Court proceedings, but even here the process does not focus primarily on obtaining services for the child. The social agency and the physician concerned with obtaining services for the abused child must recognize the role they play in the court proceedings. When a social agency determines to bring a juvenile court proceeding for child abuse, it necessarily becomes plaintiff in the case. It no longer is objectively assessing the child abuse; it has decided that the parent's conduct is sufficiently bad to warrant court intervention. At the judicial hearing, the judge, by the very nature of his role, must weigh the evidence of both the petitioning agency and the defendant parent—with the burden of proof being with the agency. The evidence of abuse or neglect—usually medical fact—is frequently contradicted by the parents' story, and the old bugaboo, reluctance to interfere with the sanctity of the parent–child relationship, recurs in the courtroom.

Ironically, however, the fact is that most parents *do* have their child's interests at heart; thus, the cause of the problem's original identification may be the best source of its solution. In the disposition of some cases, society's agents may make use of the likelihood that love exists among parents and children to help parents who would batter their children become more like the vast majority who do not. This possibility—that, between episodes of abuse, there may be love in the home, sounds a positive note in an area whose resolution remains speculative. An accurate diagnosis of child abuse, then, can lead to a guarded prognosis for recovery.

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Snowmobile: Fun and/or Folly

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THE SNOWMOBILE HAS ASSUMED a prominent position in Americans' winter sports activities. It is becoming a cause of an increasing number of injuries and fatalities.

Our purpose is to present a statistical survey of snowmobile injuries presenting for treatment at Waukesha Memorial Hospital during the winters of 1969–70 and 1970–71.

The first snowmobile is said to have been assembled in 1958.[1] Armand Bombardier of Valcourt, Quebec, Canada, is given credit for its development. By manufacturers' estimate one million were in use in January of 1970.[1] The snowmobile consists of a metal frame with a cleated rubberized track (usually 18 inches by 6 feet) powered by a gasoline engine (5 to 20 or more horsepower) whose maximum speed is usually more than 35 mph. Racing models are available with speeds in excess of 100 mph. The engine is placed in front with a padded seat over the track. The machine carries (1 to 3) passengers and can be used to tow sleds and skiers. The weight of the machine varies from 400 to 1,000 pounds. Because of a high center of gravity, its lateral stability is poor, making the machine liable to tip when traversing inclines. The maneuverability is limited because of a long turning radius.

Previous studies indicate that lower extremity injuries predominate, and open comminuted fractures of the leg are not rare. A "wishbone" injury has been described occurring when the victim's knee protrudes beyond the side of the vehicle and is caught by a tree or post. Compression fractures of vertebrae, usually at the dorsolumbar junction, commonly occur from jumping. A force of 6.5 g can be produced by jumping off a five-foot bank at 30 mph. Serious head and ocular injuries commonly occur. Drownings have been reported when the snowmobile plunged through thin ice on a frozen lake. Decapitations, cervical spine injuries, and fractured larynges have occurred when an unseen overhead wire or fence was struck. These latter injuries usually occur at night. The lighting on the machine is designed primarily to show the path or trail ahead, and objects three to four feet off the ground frequently are not seen. Near asphyxiation and "skinning" of the neck has resulted from trapping of long scarves in the engine or track.

The mechanism of most injuries has been: (1) falling from the moving snowmobile, (2) collisions, (3) being struck by an object thrown from the engine or track, (4) jumping, and (5) tipping over. Thermal injuries have been reported by "windchill" and exposure in long walkouts from disabled vehicles. Myocardial infarctions occur and appear to be related to poor prior physical conditioning. Most injuries have resulted from the imprudent use of the snowmobile and have been associated with excessive speed for conditions, poor visibility, alcohol, poor personal equipment, and inexperience with the machine.

Currently there are 4,200 snowmobiles registered in Waukesha County. Registration is mandatory.

SUMMARY OF INJURIES BY DIAGNOSIS
SNOWMOBILING ACCIDENTS
Waukesha Memorial Hospital
1970–1971

Abrasion	7	
Concussion—cerebral	1	
Contusion	20	
Dislocation	1	
Foreign Body	1	
Fracture—hand	1	4 upper extremity
wrist	2	
arm	1	
foot	2	7 lower extremity
ankle	2	
leg	3	
face	1	
compression	2	
ribs	2	
posterior (C-1)	1	
Hematoma	2	
Laceration—face	6	
extremity	6	
Sprain	9	

Figure 1

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Doctor Carnesale is Orthopaedic Surgeon at Waukesha Memorial Hospital.
Sister Prusinski is Administrative Resident at Waukesha Memorial Hospital; is presently Assistant Administrator at Elmbrook Memorial Hospital.
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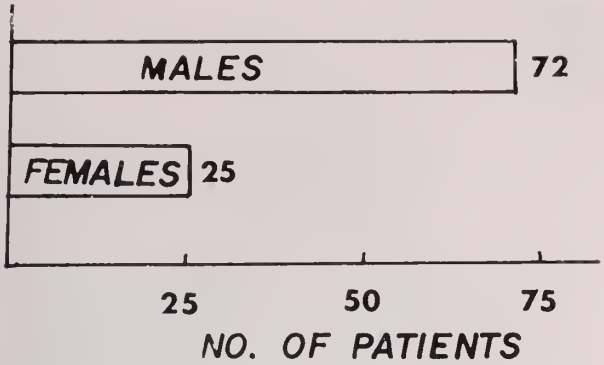

Figure 2—Injuries, Waukesha Memorial Hospital, 1969–1971. Males predominated 3:1.

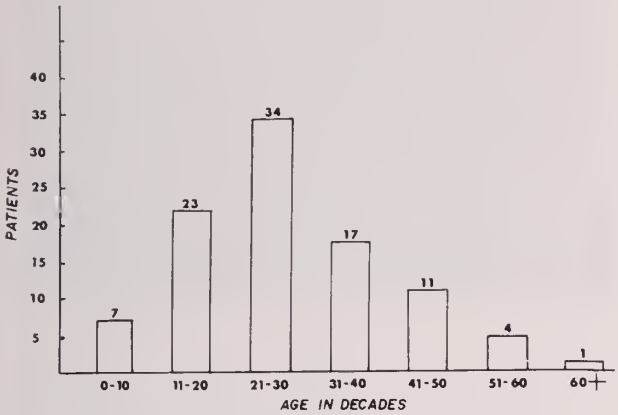

Figure 3—The age group of 11–40 years accounted for 75% of the injuries, Waukesha Memorial Hospital, 1969–1971.

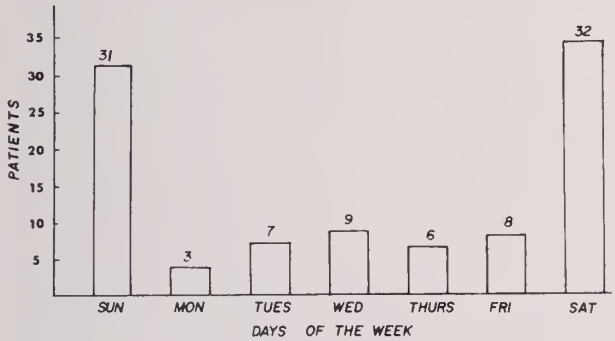

Figure 4—Two-thirds of the injuries occurred on weekends, Waukesha Memorial Hospital, 1969–1971.

Waukesha Memorial Hospital is a 420-bed general hospital in a county with four other major hospitals; thus, we see only an indeterminate percentage of the snowmobile accidents.

Analysis of the injuries presenting for treatment at Waukesha Memorial Hospital has revealed 39 injuries during the 1969–70 winter (November–March) and 58 injuries during the 1970–71 winter (Fig 1). Males have predominated 3:1 (Fig 2), and the age group 11–40 years has accounted for 75% of injuries (Fig 3). Two-thirds of the injuries have occurred on the weekend (Fig 4). Daytime (8:00 AM to 5:00 PM) and night-time injuries were equal. Seven and seven-tenths percent of the patients required hospitalization in 1969–70 and 17% in 1970–71. The average hospital stay was four to five days. Right and left-sided injuries were equal.

Questionnaires were sent to 58 patients injured in 1970–71; 29 answered. The driver was injured four times as often as the passenger. Two-thirds of those injured required treatment for less than one week but one-half were disabled for more than one week. One patient sustained an injury resulting in permanent disability. One-third of the injuries resulted from collision. Visibility was judged fair or poor in more than 50%. Alcohol was used by more than 30% of those injured. Two-thirds of those injured were traveling alone. Five percent of injuries resulted from jumping. Half of the injured had used a snowmobile for more than one year. Only 15% of the injuries were felt to be due to mechanical failure of the machine. Fifteen percent of the patients had had prior injury on snowmobiles.

Improved safety in use of snowmobiles is necessary and possibly would be achieved by a proper program of education for the user with consideration of licensing requirements comparable with other motor vehicles. Adequate personal equipment including helmet and goggles are essential. A plea is made to the manufacturers for improved maneuverability and lateral stability. Waukesha Memorial Hospital is maintaining a continuing study and analysis of snowmobile injuries.

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Snowmobiling Injuries

JAMES J MONGÉ, MD, Duluth, Minn; and NICHOLAS F REUTER, MD, Great Falls, Mont: *Arch Surg* 105: 188–191 (Aug) 1972

During a study spanning 201 days, 267 persons were injured in snowmobile accidents. The majority of the patients were teenagers and young adults, usually male, and 75% of the injuries occurred during the weekend, either in mid afternoon or evening. Alcohol was a factor in two fifths of the accidents, and it figured prominently in the more serious injuries. Soft tissue injury, when not associated with more serious damage, was sustained by 139 patients, and ligamentous or cartilaginous tears by 55 patients. Seven patients had dislocated joints, and 55 patients fractured a total of 83 bones. Fourteen patients sustained visceral injury including brain damage, and three of these patients died. □

Interstitial Pneumonia in Infancy Masquerading as Congenital Heart Disease

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AGGRESSIVE INTERVENTION utilizing cardiac catheterization and, if necessary, surgery has become routine in the diagnosis and treatment of infants with suspected critical congenital heart disease.[1,2] Often the clinical findings in congenital heart disease and pulmonary disease overlap, and it is difficult to decide which of these two organ systems is contributing to an infant's distress. Cardiac catheterization in such circumstances becomes mandatory in spite of the higher risk.[3]

We recently have cared for a six-week-old male infant, who presented with clinical signs and laboratory evidence that suggested the presence of congenital heart disease. Salient clinical findings included cyanosis, a continuous murmur, and right ventricular hypertrophy. There was radiologic evidence of decreased pulmonary blood flow. Cardiac catheterization failed to reveal any anatomic congenital heart anomaly, but abnormal physiologic data revealed pulmonary artery hypertension and a right-to-left ductal shunt. Microscopic examination of the lungs on postmortem examination showed interstitial pneumonia and changes in the architecture of the pulmonary arterioles consistent with pulmonary artery hypertension.

We believe this to be a unique situation which emphasizes the confusion that may arise in attempting to distinguish between congenital heart disease and pulmonary disease in the very young. In addition, the presence of a loud continuous murmur due to reversed ductal flow is a rare occurrence.

Clinical History

The infant was transferred at six weeks of age because of cyanosis and tachypnea. Pregnancy and delivery were uncomplicated; birth weight was 8 lb 3 oz. Tachypnea developed three hours following delivery. A right pneumothorax involving 20% of lung volume was thought responsible. Conservative treatment was successful, and the infant was discharged from the hospital at the age of 10 days.

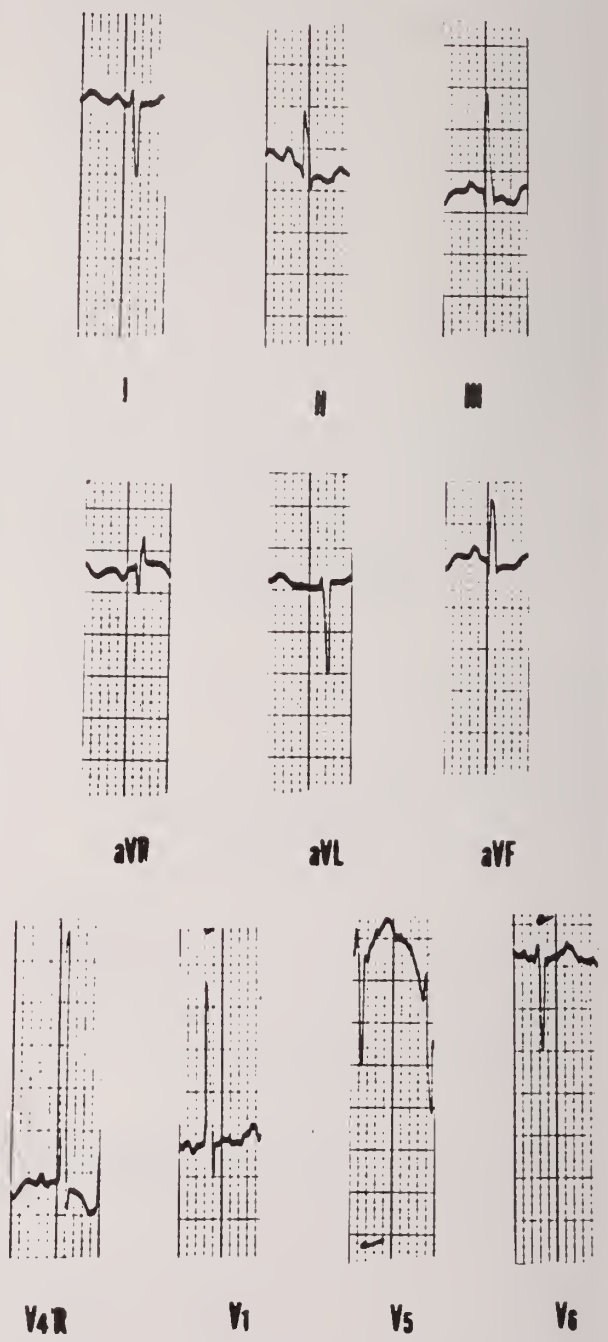

Figure 1—The electrocardiogram shows right axis deviation and significant right ventricular hypertrophy.

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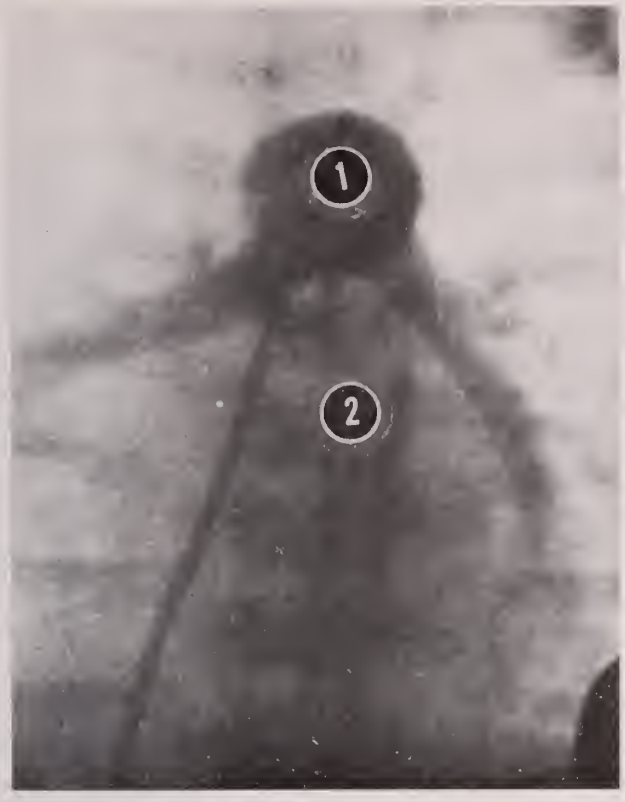

Figure 2—Cineangiogram from the main pulmonary artery showing dilated pulmonary artery (1) and filling of the descending aorta (2). Peripheral pulmonary arterioles are decreased.

Figure 3—Left ventricular cineangiogram. The arrow points to the negative washout of dye due to the right-to-left shunt through the ductus arteriosus.

At home, progressive dyspnea and tachypnea again developed. Prior to admission to the hospital, the respiratory distress was accompanied by cyanosis, and morphine was required for relief of symptoms.

On admission, he was deeply cyanotic with a heart rate of 160 per minute and a respiratory rate of 60 per minute. Except for a right inguinal hernia, abnormal physical findings were limited to the cardiovascular and respiratory systems. Auscultation of the chest revealed normal breath sounds without râles or ronchi. A right ventricular heave was present along the sternal border. First and second heart sounds were single, and the second sound was accentuated at the second left intercostal space. A loud grade IV/VI continuous murmur was heard in the same area. No other systolic or diastolic sounds were present, and all pulses were bilateral and equal.

The electrocardiogram gave evidence of right axis deviation, right atrial hypertrophy, and right ventricular hypertrophy (Fig 1). The chest x-ray film showed cardiomegaly with decreased pulmonary vascularity. Arteriolized capillary blood had a measured PO_2 of 28 mm Hg.

The presence of cyanosis, a loud continuous murmur, right heart enlargement and decreased pulmonary blood flow suggested the presence of pulmonary stenosis or atresia with a left-to-right ductal shunt (Tetralogy of Fallot or variant). Accordingly, catheterization was performed soon after admission.

Cardiac Catheterization

Catheterization results are summarized in Table 1. The salient physiologic findings included: (1) no evidence of a significant left-to-right shunt, (2) a right-to-left shunt at the ductal level with descending aorta saturation lower than that of the left ventricle, (3) left atrial desaturation, due to either pulmonary venous desaturation or right-to-left shunting at the atrial level [the pulmonary veins could not be entered], and (4) right ventricular and pulmonary artery hypertension at suprasystemic levels. Cineangiograms from the pulmonary artery revealed a large main pulmonary artery, diminished pulmonary arterioles and filling of the patent ductus arteriosus and descending aorta (Fig 2). Left ventricular cineangiograms confirmed the absence of a ventricular septal defect. A negative washout of dye in the aortic arch, due to a right-to-left shunt from the patent ductus arteriosus, was noted (Fig 3).

Course

The condition of the infant deteriorated further, following catheterization with increasing cyanosis and respiratory distress. In spite of vigorous attempts at resuscitation, he died seven hours after the study.

Postmortem Findings

The heart weighed 41 gm—about twice normal for age. Cardiomegaly was due to right atrial and right ventricular hypertrophy (Fig 4). Wall thickness of the right ventricle was 0.7 cm. The foramen ovale was patent, the main pulmonary artery markedly dilated, and a large patent ductus arteriosus 0.5 cm in diameter was noted. No other gross abnormalities were noted in the heart. Microscopic examination revealed interstitial edema of the myocardium with some degeneration of muscle cells. Other changes were nonspecific.

Lung surfaces were pale and nodular and were relatively avascular. Histologic findings included a diffuse interstitial pneumonia with thickened interalveolar septae. Histiocytes, foam cells, lymphocytes, and hemosiderin were noted. No giant cells or pneumocytes (as seen in desquamating pneumonia) were seen—nor were any bacteria present. Pulmonary arterioles had medial muscular hypertrophy and thickened intima. The elastic tissue layer was markedly increased and in some cases, their lumena were pinpoint (Fig. 5). There was no evidence of intravascular clotting. Bacterial cultures were negative, but unfortunately, viral cultures were not obtained prior to death.

Discussion

Reversible cardiac enlargement in infancy due to pulmonary disease was reported by Green and Apley in 1950.[4] Pathologic lung conditions included intrauterine aspiration, infection, atelectasis, and broncho-pneumonia, all confirmed at autopsy. Abrams[5] reported a 5-week-old male infant with respiratory distress due to absence of upper lobe bronchi, who had a reversed ductus arteriosus. On angiocardiography, the descending aorta filled from the pulmonary artery.

Cor pulmonale in infancy simulating congenital heart disease has been previously described.[6, 7] What makes this case unique, was the presence of a continuous murmur due to right-to-left ductal flow with suprasystemic right-sided pressures. In previous reports,[1, 8, 9] reversed ductal flow was manifested clinically by a short systolic murmur. The association of cyanosis, a continuous murmur and radiologic evidence of decreased pulmonary blood flow led to the erroneous clinical diagnosis of Tetralogy of Fal-

Figure 4—External view of the heart and lungs. Note the large right atrium (1) and right ventricle (2). The pulmonary artery (3) is markedly dilated. A large thymus (4) is also present.

TABLE 1—*Catheterization results*

Catheter Position	O_2 Saturation (%)	Pressure (mm Hg)
Right atrium	69	a = 10 v = 7 (5)
Right ventricle	67	98/8
Pulmonary artery	69	114/51
Left atrium	74	a = 11 v = 6 (5)
Left ventricle	74	72/3
Descending aorta	66	102/32 (57)

lot or a variant, thus confusing pulmonary disease with a congenital heart anomaly.

It is assumed that this infant had primary pulmonary disease since birth, and this was reflected in the early pulmonary difficulties. Pulmonary hypertension developed secondarily to this. Hypoxia contributed to delayed ductal closure and the pulmonary hypertension resulted in a right-to-left shunt through this persistent connection. The etiology of the interstitial pneumonia remains unknown. The histologic appearance and clinical history suggested a viral infection which may have developed in utero or immediately after birth. However, the mother remained well and no other evidence of viral illness was noted on the postmortem examination.

Summary

A six-week-old infant with clinical and laboratory evidence of cyanotic congenital heart disease and decreased pulmonary blood flow is presented. On cardiac catheterization, no heart anomaly was noted. At postmortem examination, interstitial pneumonia and histologic evidence of pulmonary artery hypertension was noted. The case is presented to show how easily pulmonary disease may masquerade as heart disease in the newborn and to emphasize that right-to-left shunting through a ductus arteriosus may produce a continuous murmur.

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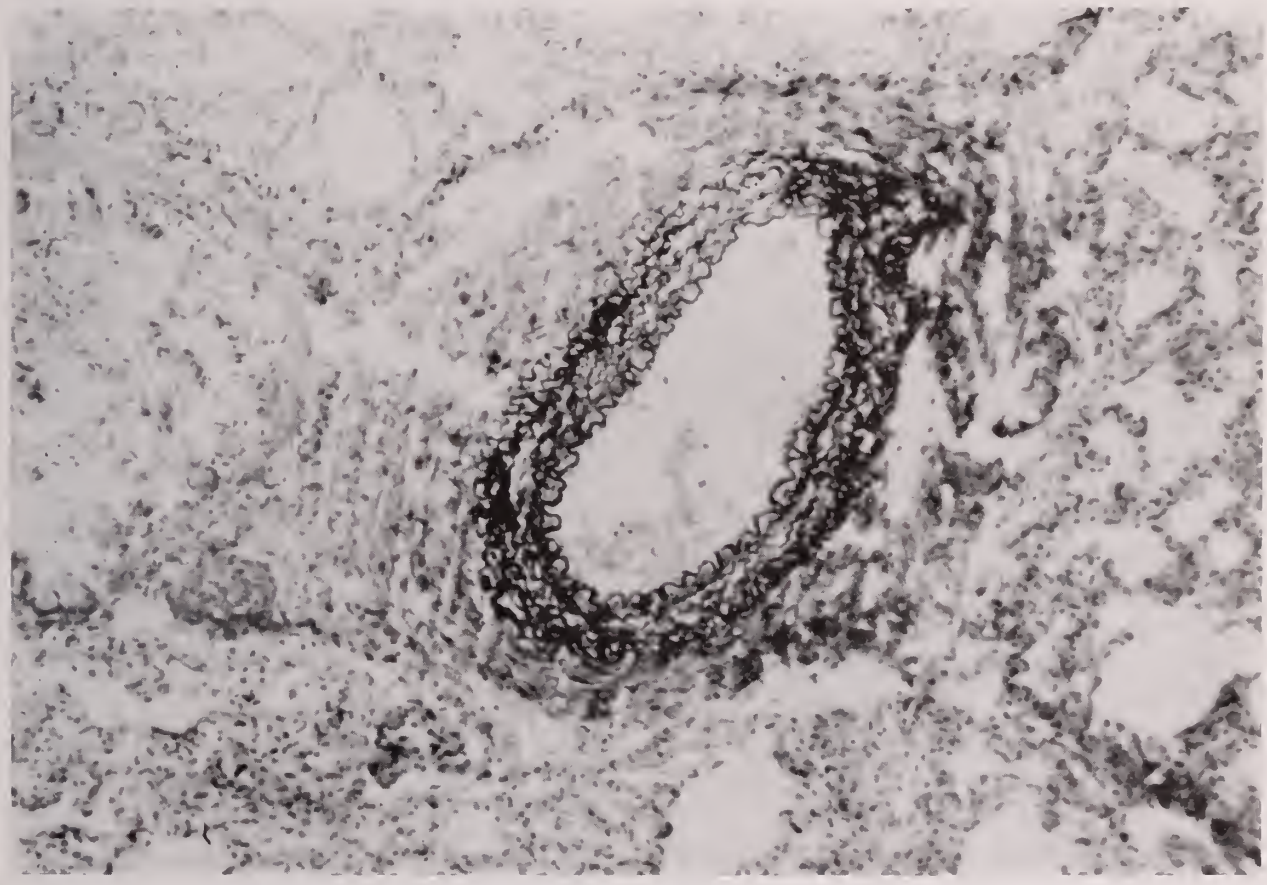

Figure 5—Photomicrograph of the lung. The pulmonary arteriole has a thickened elastic tissue layer. Thickened alveolar septae and round cell infiltrates are seen.

Treatment of Retinoblastoma

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Comments on Treatment

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RETINOBLASTOMA IS A TUMOR of the neuroblastoma family and remains as the most common intraocular tumor of children and infants. It is believed to arise from primitive retinal tissue with an incidence of one in 25,000 births. Ninety-four percent of all retinoblastomas have a spontaneous mutational derivation, 25% of these cases being of genetic mutation and 75% of a somatic type. The remainder of the total cases, 6%, have autosomal dominant inheritance with 80% penetrance. Overall, 33% of cases are bilateral. The mortality rates, which are the same for bilateral as well as monocular tumors, indicate that approximately 50% of the fatal cases die of central nervous system metastasis and extension while the remainder die of hematogenous dissemination. Utmost in treatment considerations is the early detection and initiation of therapy. Once there is orbital extension of the tumor outside the globe, the gravest prognosis is established.[1]

The clinical presentation is that of leukocoria (white pupil), strabismus, a painful red eye, hyphema, or combination of the above. Unfortunately the significance of these manifestations may not be appreciated in the early stages thus postponing treatment.

The ophthalmologist is thus faced with a two-pronged dilemma. His first consideration is effective treatment for the prevention of tumor metastasis and death while trying to simultaneously preserve the optimum visual capability of the involved eye(s). This is not a therapeutic problem for the monocular case, but becomes a serious problem with bilateral cases.

From the Medical College of Wisconsin, Department of Ophthalmology, Milwaukee.

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The advised therapeutic management of the monocular case is still uncategorically enucleation. If done before extension or metastasis has occurred, it proves curative.[2] Usually enucleation is necessary to establish a tissue diagnosis. However, if both eyes are involved, only the eye with the greatest involvement is usually enucleated. The treatment of the remaining eye involves the ophthalmologist, chemotherapist, radiotherapist, vascular surgeon, hematologist, and pediatrician. Traditionally, under the leadership of the ophthalmologist, a true team effort is necessary in the attempt to prevent a second enucleation and preserve as much sight as possible without the occurrence of metastasis.

In recent years many different modes of tumor eradication have been employed for the treatment of the second involved eye; diathermy, cryotherapy, light and laser photocoagulation, beta, cobalt, electron and x-ray beam irradiation, radon and other isotope seed implantation, and oral, parenteral or intracarotid chemotherapy.[3–6] Because of such a multi-disciplined treatment, the medical center proves best for the undertaking.

Two infants, private patients of the retina service (TMA) of the Medical College of Wisconsin, recently had good results with combined intracarotid chemotherapy, radiation therapy, and subsequent photocoagulation and cryotherapy of the second eye with bilateral retinoblastoma. The patients, 4 and 22 months of age, were first cousins and had bilateral lesions. Each child had previously undergone an enucleation of the most involved eye. The oldest child initially received 4000 rads of combined betatron and electron beam therapy followed by intracarotid perfusion of chemotherapeutic agents following previously published protocols.[7–9] The second child had chemotherapy first, the preferable course, followed by a lesser radiation dose.

Traditionally, triethylene melamine (TEM) or vincristine have been used in this technique, delivered via a canula into the internal carotid artery.[10] Toch and associates have effectively used a series of three anti-tumor chemotherapeutic agents via intracarotid perfusion.[11] Following this latter protocol, a five-day course of chemotherapy was begun. The catheter was placed by the surgical service under general anesthesia. While in the operating room, fluorescein dye was injected into the catheter; and a rapid flush of fluorescein in the fundus of the eye was noted by indirect ophthalmoscopy with a cobalt blue filter, indicating catheter placement in the internal carotid artery at least in close approximation to the take-off of the ophthalmic artery. This is important since rarely the ophthalmic artery comes off the external carotid artery—if so, there would be no perfusion of the eye by placement of the catheter in the internal carotid. A constant perfusion pump (Harvard) is used to perfuse the following three agents, each over an eight-hour period: actinomycin D, 12 mcg/kg of body weight; methotrexate, 1.25 mg total daily dose; and thio-tepa, 0.2 mg/kg of body weight. This series of three agents is then constantly infused in the common carotid artery over a twenty-four hour period and repeated daily for a five-day course. Therefore, a constant infusion is running at all times for five days. Subsequently, cryotherapy and photocoagulation were applied to the tumor at four-to-six-week intervals.

The second case was treated in a somewhat different manner. It was felt best to arrange the sequence of therapy differently, giving the intracarotid chemotherapy before irradiation, thus theoretically perfusing the tumor optimally before radiation could cause vascular sclerosis of the tumor and restrict the perfusion effectiveness of the three anti-tumor agents. Subsequently, electron beam irradiation, utilizing a five cm cone and a total external dose peak of 2729 rads, and Xenon photocoagulation were employed.

Both infants have thus far done well with only minor problems of catheter clotting handled adequately by low doses of heparin in the infusion apparatus. During post-treatment followup, residual tumor foci in both children have in fact shown remarkable regression in size. Routine periodic lumbar punctures and bone marrow aspirations or biopsies for the detection of metastatic extensions have been within normal limits.

The eye must be observed under anesthesia examination at least every three to four weeks during the period of cryotherapy and photocoagulation because necrosis of the tumor may occur rapidly causing a marked uveitis with secondary glaucoma. Retrobulbar steroids are employed in such an event.

Accordingly, the authors now institute the following protocol for the treatment of a second-eye involved in a child with retinoblastoma (in this order):

(1) Enucleation of the most involved eye.
(2) Intracarotid perfusion:
    (a) *Actinomycin* D: 1.2 mcg/kg of body weight over eight hours.
    (b) *Methotrexate:* 1.25 mg (set dose for all babies independent of weight) infused over eight hours.
    (c) *Thio-tepa:* 0.2 mg/kg of body weight over eight hours.

All three of the above are then repeated five times over 24-hour periods in a constant perfusion lasting five days (chemotherapy regimen of Toch, et al).[11]

(3) Electron (or beta) irradiation under the direction of the Radiotherapy Department.
(4) Cryotherapy to residual tumor, affecting the external portions of highly elevated masses and Xenon arc photocoagulation to affect the internal (vitread) portions.
(5) Followup periodic lumbar taps for cerebrospinal fluid and bone marrow examinations, as well as a complete pediatric physical exam is considered essential with repeat ocular exam to detect new tumor foci (i.e., it is a multicentric tumor).

The above therapy is indeed complicated and requires long hospitalization with the combined effort of a multi-disciplined group. However, it seems to be best for the young retinoblastoma patient facing death on the one hand or perhaps a productive normal life span with some useful vision on the other. Long-term followup will prove its relative effectiveness as more cases are gathered throughout the country.

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Aseptic Necrosis of Bone Secondary to Occupational Exposure to Compressed Air: Roentgenologic Findings in 59 Cases

J R NELLEN, MD and E P KINDWALL, MD, Milwaukee, Wis: *Amer J Roentgen Rad Ther & Nucl Med* 115:512–524 (July) 1972

Aseptic necrosis of bone occurring in workers subjected to compressed air has been considered to be a rare disease in modern times; however, we have had the opportunity to investigate a number of men working under compressed air and the results of our investigation have been so startling that it was thought advisable to report our findings.

During the past two years we have seen approximately 90 patients suffering from decompression sickness. These patients were employed in underground sewer tunnel construction and have been decompressed in the hyperbaric chambers at St. Luke's Hospital, Milwaukee, Wis., because of development of the "bends." These patients were also subjected to a roentgenologic survey to determine whether aseptic necrosis of the bone was present. Because of the high incidence of positive findings in the preliminary survey, new decompression tables were introduced and pre-employment bone surveys became obligatory in caisson workers by state law.

To date we have examined 169 workers who have experienced air pressures of 17 p.s.i.g. or greater during their employment, and 59 workers (35%) exhibited roentgenographic evidence of aseptic necrosis of bone. Of the total number of 59 cases of aseptic necrosis, 42 patients (71%) demonstrated juxta-articular disease. Sixteen men were already symptomatic from shoulder or hip lesions when examined.

Of 59 patients with aseptic necrosis, 33 patients exhibited juxta-articular changes in the shoulders. This high incidence of shoulder involvement is remarkable, but may be related to the type of work, in that the shoulders and upper extremities are strenuously used by the workers in digging.

The hips also have been frequently involved with aseptic necrosis, with one or both hips being affected juxta-articularly in 21 cases.

It is rare for the juxta-articular areas of the knees to be involved but the distal femoral and the proximal tibial shafts are frequently the site of aseptic necrosis.

At least 3 of our patients have required operative intervention because of extensive destruction of the femoral or humeral head with subsequent degenerative changes which have created disability.

Four of our cases show involvement of both shoulders, both hips, and both knees.

Minimal roentgenographic changes are difficult to identify and interpret. Excellent quality radiographs and an acute awareness of minimal radiographic changes, coupled with experience in interpretation, will provide the best diagnostic accuracy.

Radiographic illustrations of the various forms of bone aseptic necrosis are included in the original manuscript. □

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A Postanesthesia Recovery Score

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Waukesha, Wisconsin

THE COMPLEXITY OF ANESTHETIC management has increased many fold during the past twenty years. In 1952, the recovery room was a new development—today it is routinely found in all hospitals, large and small, and has spawned a second generation in the surgical intensive care unit.

It is axiomatic that, as the complexities of various intangible factors increase, scientific man endeavors to resolve these intangibles and simplify the complexities by objective scoring or rating systems. Perhaps the best example is the Apgar rating for newborn infants, conceived just 20 years ago and now accepted as a statement of the physical condition—and prognosis—of the newborn. The American Society of Anesthesiologists' rating system for physical status is universally used as a preoperative yardstick of patient condition. Others are known to all physicians.

A postanesthetic rating system is desirable because it can provide a simple, objective description of the patient's condition upon entry into the recovery room and document his progress toward the time of discharge from this facility. As such, it will act as an alert signal to the anesthesiologist and the recovery room personnel of impending problems in the postanesthetic patient. Of great importance is the use of the rating as a guide for discharge of the patient, doing much to eliminate frictions between the floor nurses and those in the recovery room. In addition, it can provide an objective measure for retrospective studies of the effects of anesthetic variables on the overall patient picture, can earmark factors in anesthesiology or recovery room that may need improvement, and can act as the basis for comparison of various units. Furthermore, we can envision a possible application to intensive care unit patients and to a correlation with postanesthetic morbidity.

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We would like to present our experiences with a postanesthesia rating system. To the best of our knowledge, we are the only hospital in Wisconsin currently making use of such an objective measurement.

This system was first described by Aldrete in 1970[1] in a report of his experiences rating 352 random patients. An earlier system suggested by Carignan in 1964,[2] proved too complex for acceptability.

Any such system, to be effective and acceptable, should be simple, objective, applicable to all situations, and easy to remember. This is eminently true for Aldrete's system.

Method

Like the Apgar rating, the postanesthetic rating system consists of five factors relating to the postanesthetic state, each rated 0, 1 or 2. These factors are: Activity, Respiration, Circulation, Consciousness, and Color. It has been endeavored to have the elements within each factor precise, objective, simple, and commonly observed so that the rating can be applied with equal weight by any member of the recovery room team and with a minimum of "judgment" required.

The first factor, Activity, is rated "2" if the patient can move all four extremities, either voluntarily or on command, and is rated "1" if only two extremities are moved. If the patient cannot move any extremity, the rating is "0."

Respiration is the second factor and carries with it a score of "2" if there is ability to breathe deeply and cough. Limited respirations or dyspnea is rated "1," while the absence of spontaneous respiration is scored "0."

Circulation is determined by the variance of the systolic blood pressure on admission to the recovery room from the preoperative determination. A value within 20% above or below the initial determination is scored "2;" a variation between 20% and 50% is scored "1," while a greater variation is scored "0."

Consciousness is rated on the ability to answer questions "2," arousal when name is called "1," or no response "0."

A normal, pink color is scored "2," while frank cyanosis is scored "0." Any color variation otherwise, including jaundice, is scored "1."

The rating is made by the nurse who admits the patient to the recovery room at that time. It is repeated at the end of 30 minutes and again at one hour and thence at hourly intervals until discharge from the unit. The rating is made a permanent part of the recovery room record in the form of a box score.

Results

We would like to report and comment on our initial experience with a total of 456 consecutive patients. Two patients were excluded because of an incomplete rating. Ninety percent of all patients rated "5" or above on admission to the recovery room (Fig 1). The largest group (43%) was rated at "5." At the 30-minute rating period, only 54 patients scored less than "9" or "10," and at one hour only 9 patients remained at less than this score. Two patients were below this level at two hours: one of these was rated "8" and the other had been transferred to the intensive care unit with a rating remaining at "5."

It is our policy for the recovery room supervisor to routinely discharge patients to the nursing unit upon attainment of a rating of "9" or "10." (Aldrete felt that a score of "8" was satisfactory for discharge.) All other patients must be discharged or transferred only upon the specific orders of the anesthesia department. All initial ratings below "5" are called to the attention of the anesthesiologist and all below "7" at 30 minutes are likewise reported.

An examination of the performance of patients in relationship to individual factors on admission to the recovery room reveals that over 60% of patients scored "0" in Activity and Consciousness (Fig 2). In the first category, the nurses were instructed not to use painful stimuli to elicit extremity movement. Such action can be reflexly initiated even in the decerebrate patient; furthermore, there is a possibility of causing harm to the patient. It should be noted that some of these patients had spinal anesthetics; it is for this reason that "9" was considered a satisfactory score for routine discharge from the recovery room. The other category having a large number of low scoring patients was "Consciousness." We feel that this was because of our routine use of scopolamine as a premedicant. These patients typically remain somnolent for extended periods of time in the recovery room and physostigmine is frequently needed to alert them. Most patients showed slight respiratory depression on admission to the recovery room as would be expected after a general anesthetic. Circulatory stability, on the other hand, was remarkably good. Despite slight respiratory depression, the vast majority of patients exhibited normal, well oxygenated color. Patients scoring low for "Color" included several who were jaundiced as a result of their surgical disease; this was another reason for choosing "9" as a minimal score for routine discharge.

Although the patients exhibited wide variances

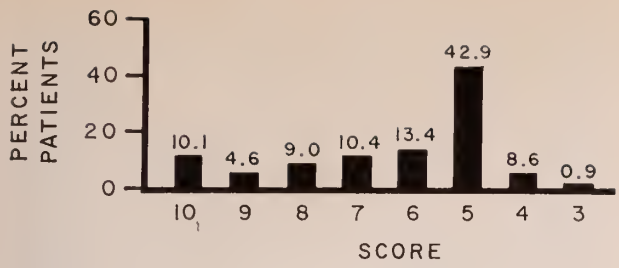

Figure 1—Rating percentage on admission to recovery room.

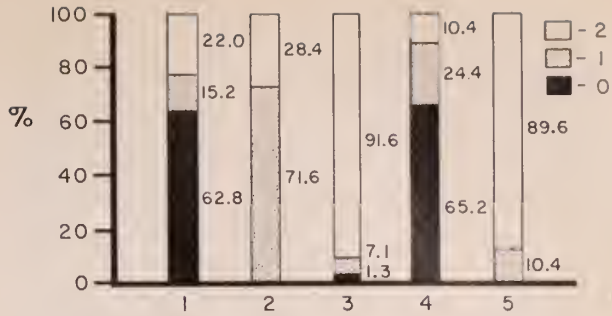

Figure 2—Scoring percentage in each factor.

in scoring between the different factors evaluated, it is felt that the overall scores were valid indications of the patient's general postanesthetic condition. The increase in the proportion of high scores with the passage of time attests to the reliability of this rating as an index of recovery from anesthesia.

Conclusions

A system of rating postanesthetic patients in the recovery room using objective criteria of various physiological parameters has been described. This system has been found to be useful in the evaluation of the patient's condition, the determination of the time of discharge from the recovery unit and in the evaluation of various factors in the anesthetic management. We plan to continue the use of this system and to correlate patients' rating in the future against anesthetic management factors and postanesthetic morbidity studies.

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MEDICAL SCENE IN WISCONSIN

Data Collecting Center May Help Cancer Patients

A data collecting center at the University of Wisconsin—Madison that is gathering information by 27 physicians in the state treating leukemia and lymphoma patients could shortly provide important answers in the management and treatment of these cancers.

The 2½-year-old project at the University's Center for Health Sciences is supported in part by grants from United Funds in Wisconsin.

Purpose of the project, according to Donald R. Korst, MD, associate professor of medicine at Wisconsin and one of the participants, is to overcome the problem of gathering a large base of statistics on the results of various types of leukemia and lymphoma treatment in as short a time as possible.

"New ways to treat leukemia and lymphoma often involve several types of drugs, longer hospital stays and closer monitoring by physicians and clinical laboratories. As new drugs and techniques are developed and used, we want to know if they are better than former types of treatment and how much better." Dr. Korst said.

Gathering the results of many doctors treating these cancers and coordinating them at a central site like the UW Center for Health Sciences will help provide meaningful data much more rapidly, he added. And eventually this data, combined with material gathered from national cancer research publications, could provide the key to more effectively treat leukemia and lymphoma.

"This is why the Wisconsin Hematology Study Group was formed in 1969," said Dr. Korst. "Today we have 27 participating physicians in Madison, Milwaukee, Marshfield, La Crosse, Green Bay, Racine, and Wood. Eight of them are at University of Wisconsin Hospitals.

Cooperating physicians send information about their leukemia and lymphoma cases, the types of treatment and the results to the study group's shared computer and statistical facilities in Madison. The group, headed this year by Lee L. Schloesser, MD of Marshfield, meets several times annually to discuss progress, methodology, and possible results.

Research funds, contributed in part by several United Funds in Wisconsin communities, are used strictly to keep the data center going, Dr. Korst pointed out. Participating physicians contribute their own time and expertise, pay their own postage and their own travel expenses to Wisconsin Hematology Study Group sessions, which often are held in conjunction with other meetings such as the State Medical Society convention. □

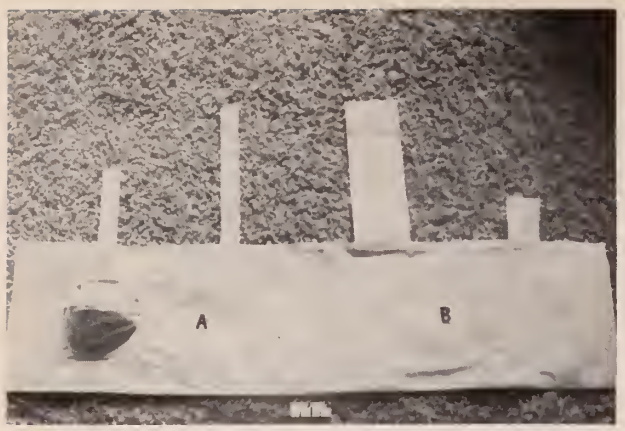

Figure 1—The mastectomy bandage opened. Part A is a soft material with a brassiere cup for the nonoperative side. Part B is two-way stretch elastic for the operative side (scale in inches).

Figure 2—The mastectomy bandage closed. All bindings are Velcro and attach in front of the patient for ease in self adjustment (scale in inches).

The Mastectomy Bandage

A New Aid for the Mastectomy Patient

JOHN T. GOSWITZ, MD
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THE RADICAL MASTECTOMY produces one of the largest raw surfaces in surgery. Early firm healing of the skin flaps to the raw chest wall is a postoperative result that is not always easily obtained. Suction catheters have improved this situation, but these only exert their effect over a short radius around the catheter.

When dressings are applied, tape and its various elasticized forms have been used to keep the dressing in place. This has provided a firm compression to eliminate dead space, but it usually leaves the patient with tape burns that are often more painful than the incision. Also, redressing these wounds has required two or three people working together to keep all the dressings in place and still apply the tape.

The use of wide Ace bandages around the thorax does not take into account the other breast, and Ace bandages have a distressing way of loosening and riding up the chest wall.

For these reasons, the new bandage shown in Figure 1 is designed specifically for use after radical or simple mastectomy. Part A (Fig 1) is a soft material for the nonoperative side and includes a brassiere cup for the remaining breast. Part B (Fig 1) is a two-way stretch soft elastic that provides steady, firm, even compression to the operative area.

Figure 2 shows parts A and B brought together and joined in the midline by the Velcro binder. The flaps on parts A and B go over the shoulders like an ordinary bra, except the flap in part B is also elasticized to provide supraclavicular compression.

All bindings are Velcro, and all attach in front of the patient so she can adjust the bandage by herself. The elastic part is designed to hold dressings firmly and evenly without the use of any tape, and dressing changes can easily be done by a single person, even by the patient herself after she returns home.

The entire garment is reversible for use on either side, is washable, and is supplied in three sizes (small, medium, and large) that will accommodate all patients.

Twenty-five patients have had this bandage applied in the operating room and have had no postoperative healing problems. Most have spontaneously remarked about the comfort and ease in its use. Surgeons who use a dressing of any kind on mastectomy wounds will find these bandages useful and a great source of comfort to their patients.

These mastectomy bandages are supplied and may be obtained as a special item from the Zimmer Company, Warsaw, Ind. 46580. □

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REYE'S SYNDROME

Two Case Reports and Literature Review

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REYE'S SYNDROME, a critical and usually fatal illness, is characterized clinically by sudden fulminating encephalopathy and liver failure. The main features are hypoglycemia, seizures, coma, increased serum glutamic oxaloacetic transaminase (SGOT) and serum ammonia, and (frequently) hyperpnea. Usually patients are less than five years old, most of them less than two. So far, no consistently effective therapy is known.

Reye's syndrome should be kept in mind when acute encephalopathy in a child is unexplained, and recognition of two features may improve the chances for survival. First, in most cases the history includes a recent prodromal infection of the upper respiratory tract. Second, the patient has hypoglycemia that does not respond to intravenous glucose.

Case Reports

Case 1. This three-year-old boy was transferred from another hospital to this hospital on April 3, 1971. He had been healthy in the past, his siblings were well, and the family history was negative. Two weeks before, he had had a mild upper respiratory infection.

On April 2 he vomited eight or nine times and complained of abdominal pain and what his mother called spasms. During the 48 hours before transfer, he had received 2.5 gr of aspirin every six hours.

At 4:30 a.m. on April 3 the child did not recognize his mother, so she took him to the emergency room of the other hospital where his physician saw him immediately and admittted him. At that time his chest had râles throughout.

Laboratory results were pH 7.35, PCO_2 25 mm Hg, sodium 145 mEq/L, chloride 114 mEq/L, potassium 5.4 mEq/L, bicarbonate 13.3 mEq/L, and blood glucose 64 mg/100 ml. Dextrose 5% in water was started intravenously and 500,000 units of penicillin injected intramuscularly. Shortly after being placed in an oxygen tent, the boy suffered convulsions and was transferred to this hospital.

On arrival at this hospital, the boy appeared extremely ill. His pupils were barely responsive to light and both were dilated, the left more than the right. He was decerebrately rigid, and all extremities were held in marked extension. His mouth was tightly closed and could not be forced open. His nose was bleeding, presumably from suctioning exclusively through the nose. There were many adventitious sounds, probably from pharyngeal secretions, but no true râles or rhonchi. Hyperventilation was marked and unceasing. Heart tones were normal. Spasm of the abdominal muscles prevented adequate examination of the abdomen.

Laboratory results were hemoglobin 13.2 gm/100 ml, white blood cell count 22,800 per cu mm with 76% segmented neutrophils, 3% banded neutrophils, 18% lymphocytes, and 3% monocytes. Platelets appeared adequate in the smear. A urinalysis was not immediately available, but catheterization 12 hours later produced 145 ml of urine having specific gravity 1.027, pH 6, no albumin or glucose, acetone 2+, and 2 to 4 white blood cells per high-power field. Later urinalysis results were no porphobilinogen, normal uroporphyrin, and "slightly elevated" coproporphyrins.

Although glucose 5% in water was running when the patient arrived, blood sugar was only 83 mg/100 ml. Blood urea nitrogen was 17 mg/100 ml, sodium 142 mEq/L, chloride 113 mEq/L, potassium 4.8 mEq/L, CO_2 7 mEq/L, SGOT 780 units/ml, serum glutamic pyruvic transaminase (SGPT) 490 units/ml, total bilirubin 0.3 mg/100 ml, total protein 7.0 gm/100 ml, and albumin/globulin ratio 1:3. Serum salicylate was 12 mg/100 ml. The results of lumbar puncture were opening pressure 33 mm of water, glucose 56 mg/100 ml, protein 14 mg/100 ml, Pandy 1+, and culture negative. Arterial blood values were PCO_2 15.5 mm Hg, PO_2 118 mm Hg, pH 7.45, HCO_3 10.5 mEq/L, and base excess —11 mEq/100 ml. X-ray films of the skull and chest were normal.

Immediately this little boy was given 45 mg of phenobarbital intravenously and oxygen by tent. Three hours after admission he received 3 mg of dexamethasone sodium phosphate intravenously and, every six hours thereafter, 1 mg intravenously. Glucose 15% in sodium chloride 0.2% was started intravenously, but the blood sugar was only 71 mg/100 ml one and one-half hours later and only 15 mg/100 ml six hours later. A mixture of 95% oxygen and 5% carbon dioxide did not increase the PCO_2 or decrease the hyperpnea, so it was discontinued after eight hours and oxygen given by tent thereafter. At this time, 30 mg of phenobarbital was given intramuscularly. By nine hours after admission, inadequate aspiration of secretions prompted a tracheostomy which reduced the hyperpnea.

Twenty-four hours after admission, Cheyne–Stokes respiration developed. The boy was no longer restless, permitting adequate examination of his abdomen, and the liver was palpable 3 cm below the right costal margin. At this time, moderate right pneumothorax developed, presumably caused by a leak from the tracheostomy. Insertion of a closed thoracotomy tube alleviated the pneumothorax.

The patient's first reaction to stimuli was minimal diffuse response to intramuscular injections about 27 hours after admission, at which time the rectal temperature was 104 F (in contrast to 99.6 F at the time of admission).

The nurse left the room, but when she returned three minutes later, heart beat and respiration had ceased. Resuscitation was futile and death was pronounced at 1:20 p.m., April 4, about 42 hours after onset of severe symptoms.

Case 2. On June 8 a seven-year-old boy had a stuffy nose followed the next day by a sore throat and fever. His family doctor injected penicillin and prescribed 5 gr of aspirin every four hours. The fever continued intermittently without abatement. On June 11 the boy began vomiting and vomited most of the following day, June 12. In the afternoon of June 13 the boy suffered tonic spasms, lapsed into coma, and was brought to the hospital unconscious.

Doctor Sen is from the Department of Pathology and Doctor Subapodok is from the Department of Neurology, Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education, Marshfield.

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Physical examination revealed a rectal temperature of 98.5 F, pulse 112, respiration 28, and blood pressure 132/70 mm Hg. The boy's neck was stiff and the rest of his body was characterized by decerebrate rigidity. Both pupils were widely dilated and unreactive to light. Eardrums were normal and the throat slightly injected. Heart tones were normal and both lungs clear. Occasionally the boy had attacks of muscular spasm during which he gritted his teeth. The abdomen was soft and flat and the genitalia normal. Deep-tendon reflexes were generally hyperactive and symmetrical. The child had bilateral extensor plantar reflex.

Laboratory results were hemoglobin 15.6 gm/100 ml, hematocrit 42%, white blood cell count 16,800 per cu mm with 1% banded neutrophils, 36% segmented neutrophils, 57% lymphocytes, 6% monocytes, and platelets adequate. The peripheral smear contained some toxic lymphocytes. Sedimentation rate was 3 mm/hr. Urinalysis was normal. Blood glucose was 44 mg/100 ml, blood urea nitrogen 15 mg/100 ml, SGOT 1210 R–F units/ml, lactic dehydrogenase (LDH) 624 units/ml, and serum ammonia 166 mcg/100 ml. Spinal fluid, obtained on admission, contained glucose 88 mg/100 ml but no white or red blood cells.

On the second hospital day, serum salicylate was 20 mg/100 ml, sodium 145 mEq/L, chloride 104 mEq/L, potassium 5.2 mEq/L, CO_2 14 mEq/L, calcium 10.4 mg/100 ml, and phosphorus 3.8 mg/100 ml. An electroencephalogram revealed delta grade II generalized dysrrhythmia (spindle coma). Intravenous glucose 5% and electrolytes produced no clinical improvement; the boy remained in coma; and hyperpnea and respiratory alkalosis developed.

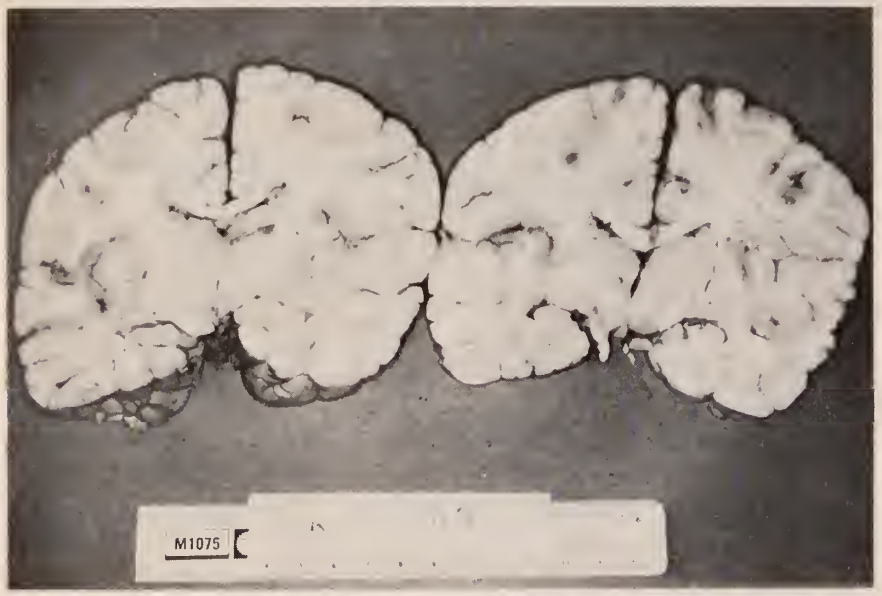

Figure 1—Cut surface of brain showing severe edema.

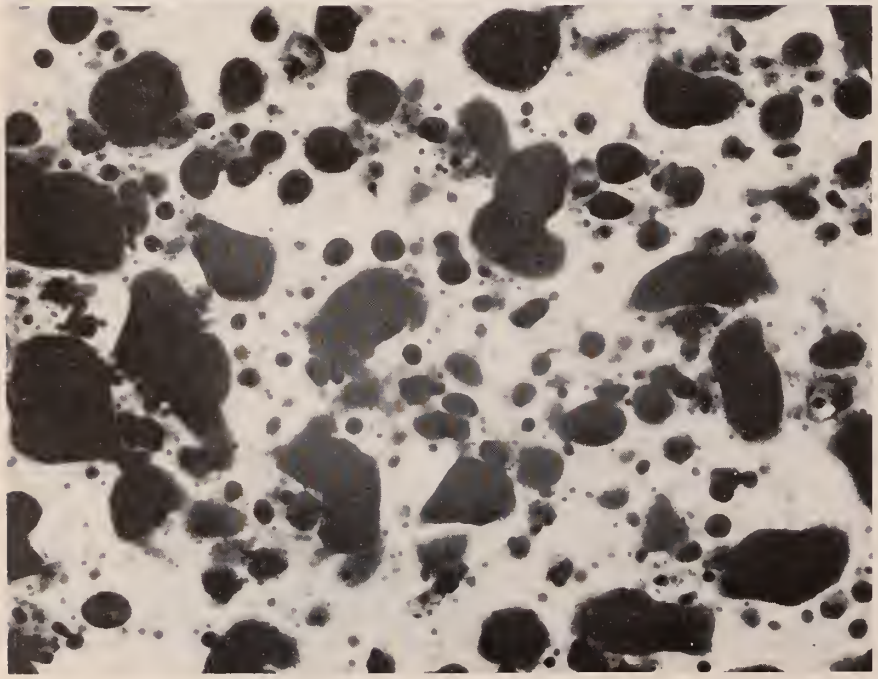

Figure 2—Liver section specially stained with oil red O showing fat globules (dark areas) within hepatic cells.

On the third hospital day, artificial respiration became necessary, and maintenance of blood pressure required intravenous infusion of levarterenol. Also, hydrocortisone acetate, 100 mg every 6 hours, was administered intravenously.

The patient died on the fourth hospital day.

Autopsy Findings

Case 1. The right lung weighed 100 gm and left lung 90 gm. The cut surface was atelectatic and congested. Some of the bronchioles contained acute purulent exudate.

The formalin-fixed brain weighed 1,350 gm. The sulci were markedly narrowed and the gyri flattened. The cerebellar tonsils were grooved. On sectioning, the ventricular system appeared markedly narrowed (Fig 1).

The other systems were essentially normal. The heart weighed 100 gm and was grossly normal except for mild flabbiness of the myocardium. The gastrointestinal system was normal. The liver weighed 600 gm. The external surface was smooth and glistening, the cut surface severely pale.

Histologically, the most striking features were noted in the lungs, liver, brain, and kidneys. The lung sections showed bronchopneumonia and severe atelectasis of the parenchyma. The inflammatory exudate within the bronchioles was acute.

Liver sections showed severe fatty metamorphosis and fatty infiltration of almost all hepatic cells. These same sections did not show eosinophilic bodies or phlebitis of the central veins. Some sinusoids contained a few round cells, but the liver parenchyma lacked spotty necrosis. There was no bile stasis. Special stains showed a severe amount of fat (Fig 2).

Histologic features of the brain were similar to those of Case 2 (following).

Case 2. The most striking organ was the liver which weighed 760 gm. The capsule was smooth and glistening and the margins somewhat rounded. The cut surface was pale and greasy.

Another striking organ was the brain. Markedly edematous, it weighed 1,500 gm. The leptomeninges were smooth and glistening, the sulci narrowed, and the gyri flattened.

Figure 3 — Gross view of stomach showing multiple superficial ulcers.

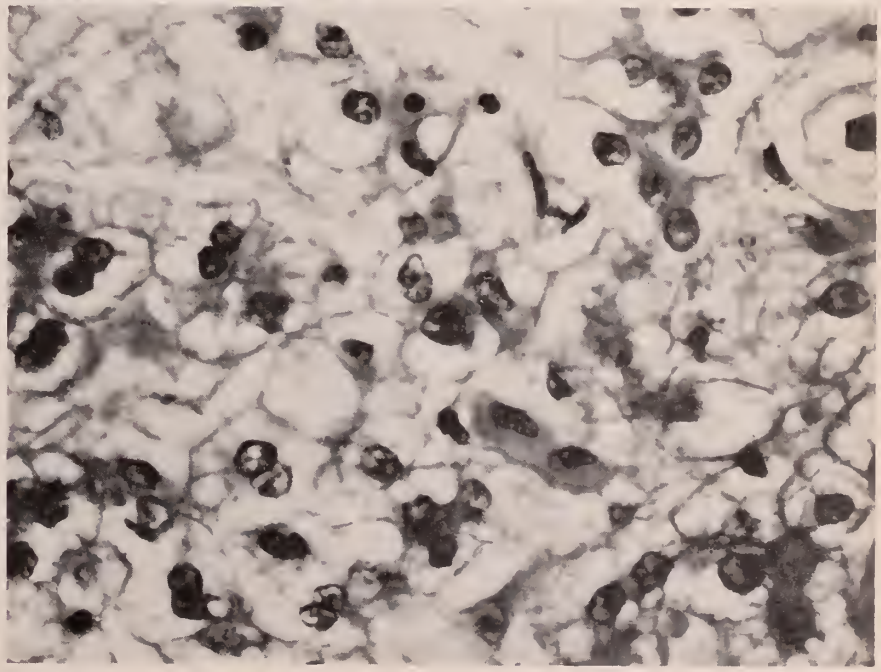

Figure 4 — Section from the liver showing severe fatty infiltration (hematoxylin and eosin stain).

The blood vessels at the base of the brain were normal. The uncus and the cerebellar tonsils were grooved. The cut surface revealed marked narrowing of the ventricular system.

The superficial lymph nodes were normal, but the deep nodes were slightly enlarged. The heart weighed 100 gm. Its external surface was smooth and glistening, and the valvular leaflets were normal. The tracheobronchial tree contained a slight amount of frothy material. The right lung weighed 130 gm, the left lung 110 gm. The cut surface was congested and atelectatic and some bronchioles contained purulent material. The spleen and pancreas were normal. The esophageal mucosa was slightly congested but not eroded or ulcerated. The stomach contained some dark brown material and had several superficial ulcers up to 1 cm across (Fig 3).

The rest of the gastrointestinal system was normal. The right kidney weighed 60 gm and the left kidney 65 gm. Both kidneys had fetal lobulations externally. The cut surface exposed medullary congestion.

Liver sections showed severe fatty infiltration that was diffuse in special stains. Perinuclear fat almost completely displaced the cytoplasm (Fig 4).

A few cells contained eosinophilic cytoplasm, but there was no eosinophilic degeneration of the hepatic cells. Occasional bile stasis was noted within the canaliculi. The portal triads were not universally inflamed as one expects in acute viral hepatitis, but some contained a few neutrophils in addition to a normal number of mononuclear cells. Hepatic cells contained no spotty or piecemeal necrosis. The sinusoids contained one or two lymphocytes and neutrophils but no eosinophilic bodies. Central phlebitis was lacking.

In sections from the cerebrum, edema was manifested by numerous pericellular and perivascular vacuoles. Occasional pyramidal cells were in various stages of degeneration. In the cerebellum, some Purkinje cells were degenerated. The external *granular* cell layer also showed loss of cellular population to a lesser degree. The external *molecular* layer was severely edematous. Sections from the pons also showed severe edema and occasional degeneration of the neurons.

Severe bronchopneumonia was evident in lung sections. The alveoli were filled with inflammatory exudate heavily mixed with histiocytes and desquamative alveolar cells. The septa were edematous and thickened, containing a few histiocytes and lymphocytes. The capillaries were congested. In many instances, the bronchioles contained inflammatory exudate and denuded mucosa.

Special stains of sections from the heart revealed a moderate amount of fat within the myocardial fibers.

Kidney sections contained adequate numbers of glomeruli. Occasional smudging of the mesangium probably was not significant. In H&E sections, the cells lining the tubules, especially the proximal, showed focal necrosis. Special stains revealed moderate amounts of fat within the tubular epithelium.

Sections from the stomach contained superficial ulcers covered with fibrinopurulent material mixed with cellular debris. The ulcerated areas showed complete loss of mucosa. In some instances, the submucosa close to the ulcers was hemorrhagic. In other instances, the vessels of the submucosa were congested and dilated. In one section, a thrombotic vessel was noted with an ulcer.

Literature Review

In 1963, Reye et al[1] described 21 Australian children, five months to 8½ years old, who suffered severe fatty infiltration of liver and kidneys associated with acute encephalopathy and, in 17 cases, seizures and death. In most cases the illness followed an infection, usually of the upper respiratory tract. Another remarkable feature was vomiting of dark brown material by 11 children, a few of whom had multiple superficial erosions of the gastric mucosa post mortem. Chemical studies revealed hypoglycemia and abnormally decreased glucose in the cerebrospinal fluid. The liver was palpable in about one-half of the patients and the liver profile included abnormal SGOT and SGPT. The authors suggested no possible etiology.

In 1964, Utian et al[2] described 14 similar cases. The illness began with mild infection of the upper respiratory tract and was followed by marked clinical deterioration to death in 11 patients and permanent brain damage in two of the three survivors. Viruses were detected in the stools of two patients.

In 1965, Golden et al[3] reported the first case of "Reye's syndrome" in the United States. A six-month-old American Indian girl was seen by her family physician on Sept. 5, 1963, for high fever and generalized seizures. Physical examination revealed pharyngitis, rhinorrhea, and scattered rhonchi throughout both lung fields. Despite treatment with novobiocin and tetracycline, the child became progressively worse. At this point, tuberculous meningitis was considered the diagnosis and the patient was transferred to another hospital. During the trip, the patient vomited, aspirated, and died. No definite etiology was suggested, but the patient had received tetracycline to which iatrogenic fatty metamorphosis of the liver has been attributed. In addition, an ECHO virus type II was isolated post mortem from the gastrointestinal mucosa, lungs, liver, spleen, adrenal glands, heart, and lymph nodes.

In 1966, Dvorackova et al[4] described 12 cases, three of them characterized by hypoglycemia. Adenovirus, type III, was isolated from the liver of one patient and possible viral origin of the disease was suggested.

In 1967, Reye's syndrome was reported from the Massachusetts General Hospital.[5] On admission, a six-year-old boy was acutely ill, and physical examination of the skin revealed a few scabby lesions thought, but not proven, to be varicella. The stomach contained 50 ml of thick brown liquid that was 4+ to guaiac. Sugar was abnormally low in the blood and cerebrospinal fluid. The SGOT was increased.

Another case was reported by Jenkins[6] in 1967. A three-year-old white girl had developed chicken

pox four days before admission to the hospital. Her serum salicylate was 8 mg/100 ml, and blood sugar was 45 mg/100 ml. At autopsy the duodenum contained bright red blood and the duodenal mucosa contained Cushing's ulcer. The authors attributed this case to chicken pox with fatty degeneration of the viscera, acute encephalopathy, and hypoglycemia.

After investigating 10 cases with similar findings, Huttenlocher et al[7] in 1969 suggested ammonia intoxication as a possible cause of the symptoms. Three of his patients had excessive ammonia in the blood which, of course, came to normal within three days. The author classified the illness as a postviral syndrome and attributed the encephalopathy to excess blood ammonia.

In 1970, Thaler et al[8] reported Reye's syndrome in fraternal twins. One died on the way to the hospital, and autopsy findings confirmed the clinical impression. The other twin survived without residual brain damage.

In a 1970 epidemiologic survey of different geographic areas, Glick et al[9] found a history of upper respiratory tract infection in 48 of 62 cases, chicken pox in seven others, and nonspecific infection in the remaining seven. Nine of the 62 patients had significantly increased blood ammonia, 23 had received salicylates, and 10 had abnormally low serum glucose. Fifteen patients survived, all without residual brain damage.

A 1971 report by Schwartz[10] described a decrease of coagulation factors I, II, VII, IX, and X, all produced by the liver.

Aflatoxin has been implicated recently by research work in Thailand.[11] This syndrome follows acute toxic hepatitis and the aflatoxin B may be the etiologic agent.

Discussion

The etiology of Reye's syndrome is not clear. Many theories have been postulated, but none is conclusive. The most significant feature is hypoglycemia that does not respond to intravenous glucose.

Ammonia intoxication has been postulated. Ammonia is formed in the intestine by the bacterial flora. From there, it is absorbed through the portal circulation where it is converted into urea by the hepatic cells. Ammonia conversion is impaired in liver disease and the resulting high concentration in the serum may cause central nervous system derangement, probably by disruption of the Kreb's cycle in the brain. Pathologically, ammonia intoxication increases the number of protoplasmic astrocytes in the cortex, a change also noticed in the thalamus, pons, and substantia nigra.

Previous viral illness has been postulated. Two of Huttenlocher's patients had suffered chicken pox as a prodromal illness.[7] The patient reported by Jenkins[6] also suffered from chicken pox. The first case of chicken pox associated with hypoglycemia with complete recovery was reported by Nader[12] in 1965, in a three-year-old girl. The patient reported from Boston[5] was thought, but not proven, to have varicella. In the epidemiologic survey of Glick,[9] seven patients had a history of chicken pox.

A third cause to be postulated is viral hepatitis. However, in acute viral hepatitis there usually is no fatty metamorphosis of the liver. Fatty changes in the liver are noted to a lesser degree if the patient is convalescent or is taking steroids or certain antibiotics.[13] Eosinophilic bodies within the Kupffer's cells are not specific for acute viral hepatitis because they are also found in (a) toxic hepatitis, (b) burns, (c) chronic passive congestion, (d) liver damage due to tannic acid, and (e) in obstructive jaundice (occasionally).[14] The important feature in acute viral hepatitis is central vein phlebitis among the other findings. Another feature in infants is giant cell formation of the hepatic cells. In other types of viral hepatitis such as varicella and yellow fever, one should find virus inclusions.

However, the possibility of a lipo-virus should be considered. In 1962, Chang[15] isolated such a virus from a patient with hepatitis. The virus produced a toxin that caused fatty degeneration within cultured human liver cells.

A fourth cause to be postulated is acetyl salicylic acid. In toxic doses, aspirin produces acidosis, associated hyperpyrexia, dehydration, convulsion, and coma. Chronic ingestion produces bleeding gastric ulcers.

There is no known effective form of therapy. Huttenlocher[7] treated three of his 10 patients with exchange transfusion, cleansing enema, and oral neomycin and was discouraged by the results. Two of these patients died. Pross[15] treated a nine-month-old infant with peritoneal dialysis. The patient survived without any apparent sequellae. Corticosteroids have been used without proven beneficial results.[7] Intravenous urea, mannitol, and dexamethasone have been recommended for reducing cerebral edema, but the outcome seems to be unaffected.

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"MINI TRANSFUSIONS" for Neonatal Patients

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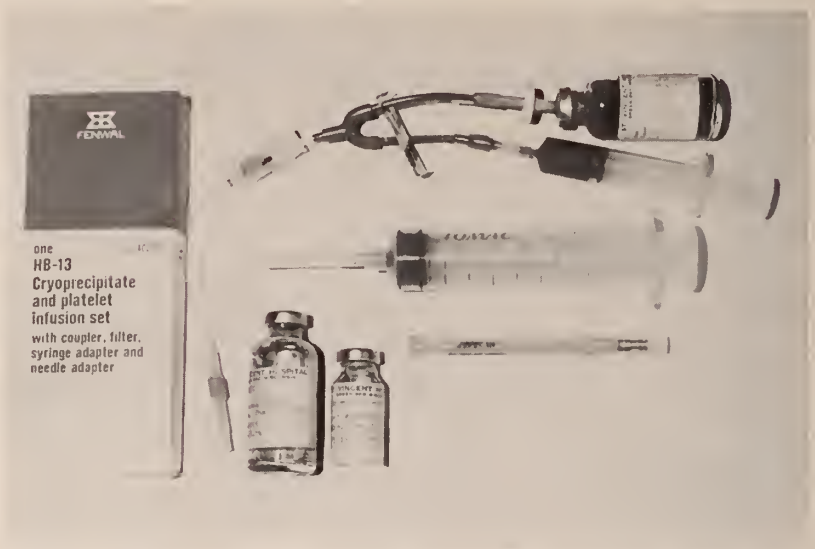
In the management of infant patients in the neonatal intensive care unit, it often becomes necessary to replace blood by infusion, because of the loss of blood due to repeated blood samples especially if blood gases are repeatedly studied. Because these amounts of blood are often small substandard amounts, the hospital blood bank has evolved a transfusion procedure which conserves blood and technologist time. Donors are selected from hospital personnel who comprise our "walking blood bank." The hospital personnel are carefully screened, regular donors, repeatedly negative for hepatitis associated antigen. The donor's arm is cleaned with surgical soap, alcohol, iodine and alcohol.*

Under aseptic technique, 40 ml of blood is withdrawn from the donor by means of a 50 ml sterile, disposable, nonpyrogenic, plastic syringe with a No. 18 needle. Thirty milliliters of this blood is immediately transferred using a second sterile No. 18 needle into a sterile, pyrogen-free, 30 ml bottle containing 1.8 ml (250 units) of heparin solution and gently mixed. The 30 ml bottles with heparin solution are prepared in the hospital pharmacy under a sterile hood. As the blood is injected into the 30 ml bottle, the procedure is facilitated by the use of a small gauge sterile needle inserted as an escape airway. The remaining 10 ml of blood is used for crossmatching, typing, HAA testing, VDRL and immune antibody screening.



The center 50 ml syringe is used for donor withdrawal. A second needle (not shown) is used for injection into the 30 ml bottle. Infusion set has a sharp plastic needle for entry into the donor bottle. The filter is located at the infusion end of the infusion set. Plasma is aspirated after centrifugation by means of the Monoject spinal needle (lower right).

The small bottle is identified and labeled, and after typing and crossmatching, is sent to the floor for immediate infusion using a cryoprecipitate and platelet infusion set (HB-13, Fenwal) which contains a fine mesh filter. This setup is a three-limbed, plastic tubing system which allows withdrawal of blood into a 10 ml plastic (Stylex) syringe. The stop-

* Technical Methods and Procedures of the American Association of Blood Banks, *Donor Arm Preparation,* 5th edition, 1970, p 15.

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REYE'S SYNDROME/Sen and Subapodok

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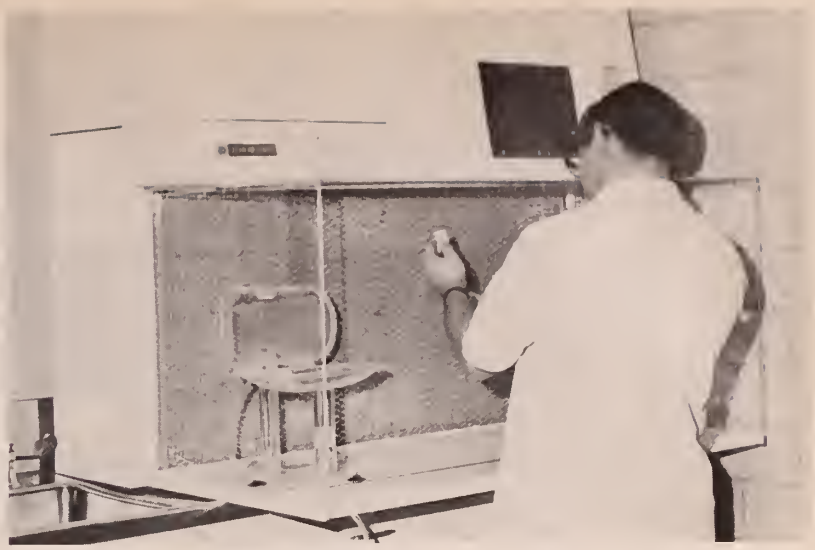
cocks are opened to the indwelling umbilical catheter of the recipient and closed to the supply bottle. The blood is then slowly infused by means of the syringe in the amount ordered by the pediatrician. These "mini-blood transfusions" are used immediately and no preservative is used with this method.

If packed red cells are ordered, blood is drawn in the same manner, but the specimen is centrifuged 10 minutes at 3000 RPM. Under sterile technique, a 20 x 3½ sterile spinal needle is used to draw off the plasma into a 20 ml vacutainer tube. The packed cells are sent to the floor and the nurse transfuses the necessary amount of packed cells using the same cryoprecipitate and platelet infusion set. The method is the same for whole blood.

The hospital pharmacy personnel prepares both 5% plasma protein fraction and 25% salt poor albumin in the sterile hood. These are available in both 30 ml and 10 ml sizes in pyrogen-free bottles. All of the solutions are administered in the neonatal intensive care unit using a platelet infusion set. The hospital maintains small, but adequate supplies of infusion bottles and sterility controls are run at monthly intervals by the department of bacteriology. Blood passed through the platelet infusion set filters is repeatedly negative for hemolysis.



Pharmacy personnel prepare the heparinized donor bottles, 5% plasma protein fraction, and 25% salt poor albumin in the Abbott Clear Air Center. The system features laminar air flow out of the hood after passing the air through high efficiency particulate arrestors (HEPA filters). Bacteriologic controls of the solutions prepared in the hood are repeatedly negative.

The pediatricians and personnel in the neonatal intensive care unit have developed great facility in the use of these small transfusions and the technique has been well accepted.

Supplies are available from the following sources:

(1) Sterile pyrogen-free glass bottles are from the Elkins–Sinn Company or USV Corporation.

(2) The infusion set is from Fenwal Laboratories, Division of Travenol, Morton Grove, Illinois, HB-13 Cryoprecipitate and Platelet Infusion Set with coupler, filter, syringe adapter, and needle adapter.

(3) Spinal needle for plasma withdrawal in the preparation of cell pack is Monoject No. 220 (20 x 3½).

(4) Syringe used for withdrawing blood from the donor is the American Hospital Supply disposable syringe, Tomac, 50 ml, lock tip.

(5) The sterile hood is Abbott Laboratories Clean Air Center, Abbott Laboratories, North Chicago, Illinois. □

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Comments on Treatment

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Since 1938, a continuous monthly scientific feature, except January and December issues, affording the physicians in the larger hospitals and medical centers the opportunity to relate their research and clinical efforts in diagnosis and treatment to the practicing physicians in Wisconsin . . . presented in cooperation with the Departments of Pharmacology and Medicine, The Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

An Approach to Behavior Disorders—Enuresis, Encopresis, and Hyperkinetic Syndrome

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ENURESIS, ENCOPRESIS and hyperactivity are common behavior manifestations for which a physician is consulted. Each of these three clinical entities has its own history. While enuresis as an entity dates back to antiquity,[1] encopresis captured the clinician's interest in the late nineteenth century.[2, 3] Hyperkinesis was accepted as an entity in the mid twentieth century.[4] All three, however, have features in common. All three are behaviors which are pathognomonic of neither organic nor emotional disturbance while they have been reported to be responsive to organic and psychological therapies based on various organic and psychological conceptualizations.

The physician might best consider each of the three as a psychophysiological disorder in the sense that each rests on an underlying constitutional malfunction that can become intimately involved with emotions and expression of emotions. When emotional factors are involved they are not in the sense of symbolic expression of conflicts via bladder, intestines, or motoric behavior. Rather as Prugh has been quoted regarding encopresis, the behavior involves "a less well differentiated handling of tensions which could no longer be successfully dealt with in a more mature fashion."[2] Put in another way, each of these behaviors can indicate that overwhelming emotional tension interferes with control of sphincters or motoric behavior. The three do have this common characteristic that allows for discussion of a clinical approach that can be a prototype for management of behavioral problems.

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A balanced approach toward psychophysiologic disorders is not easily attained. There are physiological factors and there are psychological insights that need to be integrated in the approach to these children. To strike some balance between the two, the physician first will need to approach the child's behavior with an open, inquiring mind and not from a biased position which assumes that the behavior is strictly an organic problem or that it obviously spells a disturbed youngster, even one in need of psychiatric attention.

Instead he ought to consider that the following possibilities exist in behavior disorders, be it enuresis, encopresis or hyperkinesis:

1. Behavior disorder without evidence of emotional disorder.
2. Behavior disorder with evidence of emotional disorder, but the two coincidental without established cause and effect.
3. Behavior disorder with evidence of emotional disorder and presumptive evidence of or more clearly established cause and effect relationship between emotions and specified behavior.
4. Behavior disorder with evidence of emotional disorder that is initiated or at least aggravated by this troublesome behavior.

It ordinarily is easy enough to establish the presence or absence of an emotional disorder by talking with the child directly and by learning from him and his parents whether he is a reasonably comfortable, reasonably happy child who can function well by himself and with others at home, at school, and in the community in age-appropriate activities. Admittedly, while it may be easy enough to establish the presence or absence of an emotional disorder, to determine its causal influence on particular behavior at times may be an impossible task.

It is not crucial that the physician establish whether there is a relationship between the child's emotional disorder and his behavior disorder when he initiates treatment of the child's troublesome behavior. The physician can treat the child for his behavior and treat him effectively without getting at emotional constellations that may be involved in this behavior. There may be raised eyebrows and clamorous protests of heresy at this point, especially if these behaviors are looked upon as symptomatic of underlying organic and/or emotional disorders that need to be treated.

What Mowrer[5] has commented about enuresis might be applied to all these behavior disorders, namely, to view them as "symptoms" may represent the "misapplication of a concept illicitly borrowed from adult medicine and psychopathology." Rarely if ever can one be sure that any of these behavior disorders is symptomatic of an underlying disorder, although associated physical and/or psychological disorders may be discovered in the diagnostic examination. Even when a symptomatic quality does seem evident, the problem of management is not a matter of treating the "symptom" as an entity but rather a matter of "symptomatic" treatment in isolation. That is, mismanagement ensues when attention is not paid to the child with or without the behavior so that once the "symptomatic" behavior fades, no attention is paid to the child who is left behind. For example, no attention may be given to a particular child who suffers from faulty coping mechanisms that leave him vulnerable to rigid somatic expressions through hyperactivity, enuresis, and encopresis. With such a child reasonable management might involve more than obliteration of the behavior, although there ought to be no hesitation to help change his behavior.

It would be reasonable enough, for example, to block the particular somatic route; i.e., hyperactivity, enuresis, encopresis, with the aid of medication, but it would be equally important to try to help modify the development of personality rigidities through further counselling and/or therapy with the family and/or the child. This second part of the management of the child may exceed the domain or expertise of the practicing physician who then elects that it be carried out through referral to a psychiatrist or other mental health worker.

Based on his assessment of the child, the physician initally has three options in treatment. He can offer the child treatment for his behavior disorder alone, for his emotional disorder alone, or for both. If he feels that the behavior ought to be "tackled" of itself, he ought to feel free to do so with the particular physical modality with which he is acquainted.

We will now take up the somatic treatments and the psychological interventions that go into the management of children with these behavior disorders.

Somatic Treatment

ENURESIS. Of the three clinical entities this one has the richest history of theories and treatments as has been reviewed by Glicklich.[1] Three popular somatic treatments of this disorder have been reported as highly effective.

Bell-ringing or alarm devices.[5-7] These devices operate on the principle that when the child wets a bed pad he closes an electrical circuit which activates an alarm or a bell that awakens him. The aim is to condition him to respond to the urge to urinate without wetting in his sleep.

This approach brings to mind another type of conditioning reported by Torrey.[8] He notes that in Western Nigeria a toad is tied by string to the penis of male children who wet their beds. When the child wets, the toad croaks and the child wakes up.

Enlarge bladder capacity. On the theory that enuresis is related to relatively inadequate functional bladder capacity, treatment is geared toward enlargement of the child's functional bladder capacity to a size commensurate with his age and stature. To accomplish treatment the child is to

"force fluids" during the day and is to hold his urine as long as possible. Anticholinergic drugs have also been recommended as a useful adjunct to this treatment. With this regimen Muellner[9] reported development of adequate bladder capacity in three to six weeks.

Drug therapy. Difficulties in starting micturition reported by adults on imipramine for depression led to the successful trial of this medication in the treatment of enuretic children.[10] In a double-blind, placebo-controlled study of treatment of enuretic children imipramine in doses of 25 mg for children under 12 and 50 mg for children over 12 has been reported as "markedly superior clinically and statistically in decreasing the frequency of enuretic nights."[11] In our experience bedtime doses of 25–100 mg, depending on the child's size and original response to the drug, have been very effective in the treatment of enuresis. Specifically, the initial dose of 25–50 mg may be increased by 25 mg increments until it is doubled if need be. While we have not seen troublesome side-effects with these dosages, its ability to cause hypotension needs to be kept in mind.[12]

Mechanisms for imipramine's effectiveness have been postulated to be related to its anticholinergic, to its stimulant and/or to its antidepressant effects.[11] (The last seems least plausible since the anti-enuretic effect occurs almost immediately while its antidepressant effect becomes evident only after 1–2 weeks.) Its influence on sleep patterns is also noted as possibly related to its effectiveness with enuretics.[13]

Encopresis. Successful treatment of this behavior dates back to Henoch's report of success with injection of ergotin subcutaneously near the anus.[3] (He also reported that injection of distilled water proved equally effective.)

Drug therapy. Medical management depends on which of the two types of encopresis the child presents. There is the "continuous," "non-retentive" type[2, 14] in which there is essentially no constipation and encopresis is simply a response to an urge to defecate, even while the child is likely to report little or no awareness of this urge. Such a child is the usual candidate for tricyclic antidepressants such as imipramine,[15, 16] again 25 mg for children under 12 years and 50 mg for children over 12 with the option of increasing the dosage up to double the initial dose as necessary.

Bowel management. Another approach is in order for the child with "discontinuous" or "retentive" encopresis [2, 14] in which constipation is usually notably present and encopresis is more likely to involve "fecal leakage." To overcome the child's excessive bowel control, mineral oil (15–30 ml) each day is helpful in the establishment of regular bowel movements. If the presenting constipation is severe, an initial emptying of the bowel with a laxative suppository or a saline enema may be necessary.

Hyperkinetic Syndrome. While the most recent of these three behaviors to draw the clinician's attention,[4] the hyperkinetic syndrome must vie with enuresis at least in terms of reported incidence.

Stimulants. In the medical management of hyperkinetic children, use of stimulants (amphetamines and methylphenidate, 10–40 mg a day in two or three divided doses) heads the list of drugs used. These medications "appear to mobilize and to increase the child's abilities to focus on meaningful stimuli and to organize his bodily movements more purposefully."[17] In another sense such drug stimulation is postulated to help the hyperkinetic child with an underlying low central nervous system (CNS) arousal pattern who attempts to compensate for this state by increased motor activity.[18]

Imipramine. Winsberg et al[19] have also reported on the use of imipramine (25–50 mg three times a day) in the treatment of the hyperkinetic child. As they note that 82 percent of their clinical sample were responders to dextroamphetamine, to imipramine, or to both, they observe that these two agents may constitute a highly effective pair of psychotropic drugs in the treatment of hyperkinetic children. Implied in their comments seems to be the assumption that imipramine also is effective through its CNS stimulant action.

Psychodepressants. There are also a group of hyperkinetic children who deteriorate on the psychostimulants but who appear to respond well to psychodepressants, such as chlorpromazine. These children may be those whose hyperactivity is a manifestation of cortical overload with a high arousal level of the central nervous system.[20]

From Satterfield's study[18] one could be led to use empirically the psychodepressants in children with strong family histories of psychopathology as these are the ones who seem to respond least to the stimulants and in whom there may be a significant genetic factor.

The use of the above noted medications in the treatment of these three behavior disorders does have a strong appeal on several counts. Side-effects are few and ordinarily are of little consequence. If any of the medications are to be effective, some positive

results are noted almost immediately on the initial dosage or on the higher dose. In fact, if no results are evident in at least one week on a given dose, effective use of that medication is most unlikely. The duration of therapy is related to the child's response. With some, therapy can be withdrawn in a month or so with no recurrence of the behavior. Most children will need a maintenance dose for a longer time, until new patterns of behavior are established—perhaps until more adequate CNS development is attained. In the treatment of these behaviors, the recommended medications do not alter the behaviors through changes in affect; therefore, drug dependence is not likely to develop.

Lastly, if it is determined that treatment of the behavior disorder is indicated (e.g., in the case of daily or almost daily enuresis or encopresis, hyperactivity that significantly impedes functioning in school and at home), the physician ought to pursue one of these somatic treatments in a diligently aggressive manner. The fact is that in our culture at this time any of these behaviors is apt to "blackball" a child and of itself have a deleterious impact on his personal psychological functioning as well as on his interpersonal relationships.

Psychological Interventions

Various psychological theories have been proposed in reference to each of these behavior disorders. Problems with aggression highlight discussion of emotional factors underlying encopresis[2] and enuresis,[21, 22] although different personality patterns in the two are described. Prominent in the discussion of hyperkinesis is the role of anxiety and the child's defense against painful affect.[23] These are features the practitioner might keep in his mind for ready reference if and when psychological factors are prominent in the child's management.

The physician who treats a child with one of these behavior disorders ought to start out with an assessment of the child's emotional state. That is, is there or is there not evidence of an emotional disorder? If there is no evidence of an emotional disorder, he ought to feel confident to prescribe one of the suitable somatic therapies without recommendation for further psychiatric attention. If, on the other hand, he sees evidence of an emotional disorder, even while he decides that somatic treatment for the behavior disorder is indicated, he might initiate his treatment as in the following clinical example:

> "While John sure has a problem with bedwetting (or encopresis or hyperactivity), I also find him to be a pretty tense (or immature, depressed, etc.) boy. At the moment I am not sure how much these emotional factors might play a part in his bedwetting (or encopresis or hyperactivity). However, I do suspect (or do not suspect) that they are especially involved for the following reasons (which are spelled out to the child and his family)."

Another situation prevails if the physician is convinced at the outset that the child has an emotional disorder, as diagnosed from evidences of significant disturbances in his development and not on the basis of evidencing this particular behavior disorder alone. Namely, he ought to feel free to refer the child for psychiatric treatment even while he attempts to help the child correct his behavior disorder with the aid of a particular somatic treatment.

In the more usual instance, if evidences of emotional disturbance are present, it will be a matter of reviewing the child's emotional status with an eye toward reassessing matters after a trial with medical management of the behavior. If the child then returns with improvement of his behavior and relatively settled emotionally, no further treatment will be in order. Or the child may return with improvement in his behavior but with little if any improvement in his emotional status. With him it then will be in order to delineate further the nature of his emotional disturbance and to decide more definitely what else needs to be done for him. In this light it should be noted that it may be an easier task to get the child and his family to look at his emotional disturbance once the troublesome behavior has improved as it dawns on them that the behavior had been a convenient scapegoat on which they could project the blame for his inadequacies.

This reassessment of the child's emotional status may then lead to the physician's counselling of the child and his parents or referral to a psychiatrist or other mental health worker as the physician and family see fit. On occasion we have found a hyperkinetic child who had improved dramatically in his personal and interpersonal functioning but who continued to appear unhappy and troubled within himself. Although psychiatric treatment was offered, the family refused it as they felt sufficient gains had been made.

What about the child who returns without improvement in his behavior after a reasonable trial of medical management? We would like to caution that lack of response to medication ought not by itself be the basis for further psychological assessment. However, if the behavior persists after a trial of medication and if the physician had already alerted the family to the existence of an emotional disorder, it now may be reasonable to forego further somatic attempts for the moment and deal with the child's emotional problems.

However, the physician ought not to prematurely shift his management. That is, he had better review carefully whether the child has had a fair trial on the medical treatment. He may find that the medication was not taken or was taken sporadically. If so, it will be important to try to get at factors that interfere with the family's acceptance of medical management. Reassurances, for example, that the child will not become a drug addict may suffice. Or it may become evident that emotional problems

preclude involvement in medical treatment or necessitate maintenance of the child's "self-destructive" behavior. Attention to the child's and/or family's emotional problems may now take precedence over more strictly medical management.

Comments

We intentionally began this discussion of an approach a physician might take to children's behavior disorders at the point where the physician has made a diagnosis of a behavior disorder for which treatment is required. Problems of diagnosis and determination of when to treat are left for another time. Absence of their discussion is not meant to imply that treatment should be given to every child who comes to the physician with bedwetting, soiling or complaints about hyperactivity. When to treat and when not to treat could lend itself to another paper. The task here is the development of an approach to treatment once the physician decides to treat the child for his behavior disorder. As such a systematic approach to treatment has been outlined with attention paid to both the child's behavior and coexistent emotional factors.

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Acquired Hypertrichosis Lanuginosa and Malignancy

STEPHEN I HEGEDUS, MD and WILLIAM F SCHORR, MD, Marshfield Clinic, Marshfield, Wis: *Arch Dermatol* 106:84–88 (July) 1972

We record two cases of acquired hypertrichosis lanuginosa, bringing the total number of cases reported in the literature to nine. This sudden appearance of long, fine lanugo hair in an adult is a striking cutaneous sign of internal malignancy. From our study and review, this association with systemic cancer is even greater than a review of the literature would seem to indicate. Prominent red multiple papillae appearing on the tip and distal third of the tongue appear to be an integral part of this syndrome. Two histologic features have not previously been reported. First, lanugo follicles extend almost parallel to the epidermal surface, deviating markedly from their normal near-vertical position. Second, many lanugo follicles are of the "mantle" type and contain lipidized cells within the mantle. □

Immune Thrombocytopenia Due to a Drug Metabolite

E V EISNER, MD and N T SHAHIDI, MD, VA Hospital, Madison, Wis: *New Eng J Med* 287:376–381 (Aug 24) 1972

The interaction of drugs and antibodies to produce thrombocytopenia is well recognized, but an antigenic role for drug metabolites in this disorder has not been previously recognized. A patient who developed thrombocytopenia while taking analgesics was found to have circulating antibody to a metabolic product of *N*-acetyl-*p*-aminophenol (NAPA), but not to the drug itself. The antibody present in IgG and IgA fractions of the patient's serum, reacted *in vitro* with an antigen present in the blood of a normal volunteer who had ingested NAPA. The antigenic material was purified from the urine of this volunteer and shown to be the sulfate conjugate of the drug. These findings demonstrate that a drug metabolite can be active antigen in drug-induced thrombocytopenia when the drug itself is immunologically inert. □

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Endometrial Adenocarcinoma with Cerebral Metastasis and Subdural Ossification

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OSSIFICATION OF CERTAIN TISSUES may be induced by a variety of means, although the mechanisms are not yet fully understood. In the following case report, a plaque of mature bone and bone marrow appeared between the dura and an underlying cerebral metastasis from a mucous secreting endometrial adenocarcinoma. The plaque was easily separable from the overlying dura and underlying tumor and pia. It is presumed to have developed from the transformation of arachnoidal cells into osteoblasts.

Case Report

A 63-year-old, right-handed housewife had a hysterectomy in another hospital in September 1970. A mucous secreting adenocarcinoma of the endometrium was demonstrated histologically in the removed uterus, without evidence of regional extension or distant metastasis at that time. The patient also had a history of mild diabetes mellitus controlled with tolbutamide (Orinase®); and was receiving digitalis derivatives because of hypertensive arteriosclerotic cardiovascular disease with borderline congestive heart failure.

In early March 1971, she began having episodes of numbness and spasm on the left side of her face. These progressed in frequency and severity. By the end of March 1971, there were frank, left Jacksonian seizures, with a progressive residual left hemiparesis following each seizure.

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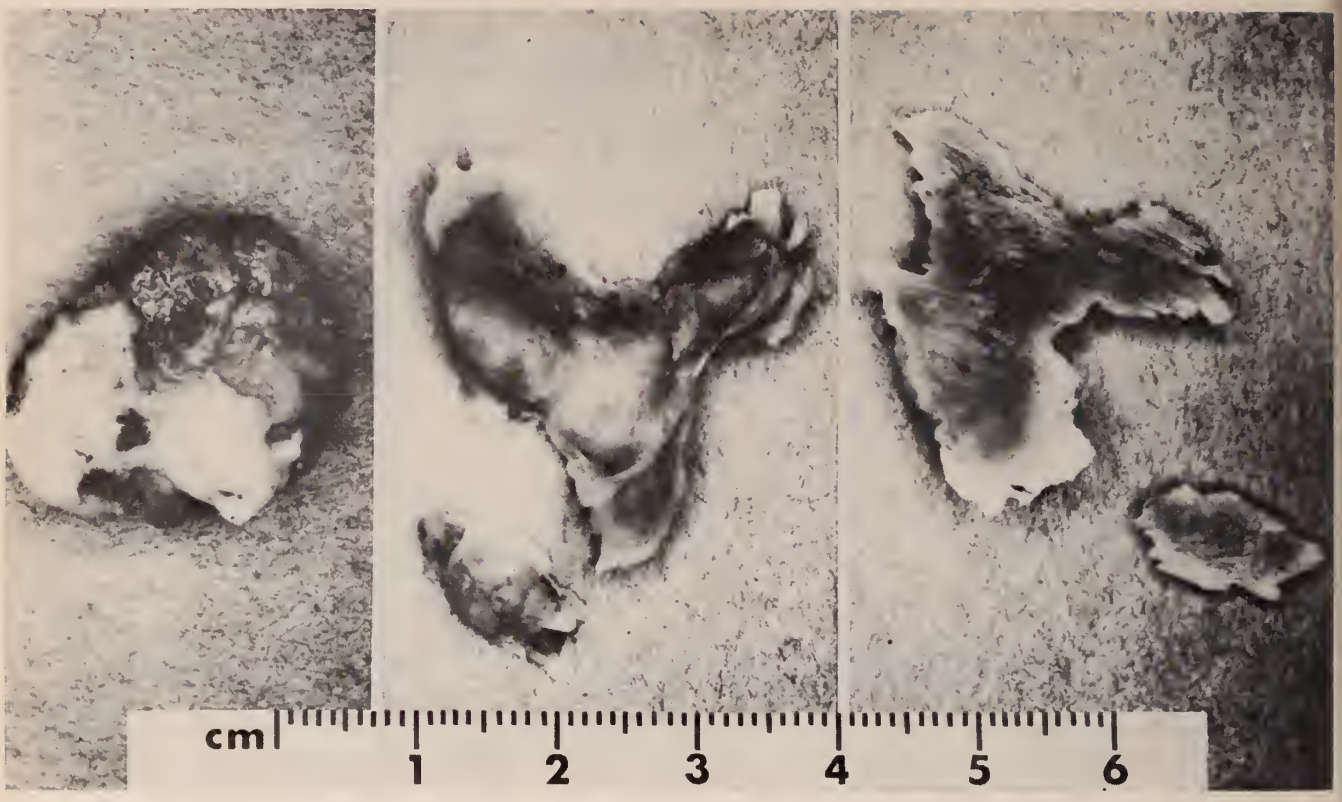

Figure 1—LEFT: Metastatic adenocarcinoma of endometrium, removed from right fronto-temporo-parietal region of brain. CENTER: Inner surface of bone plaque overlying the metastatic tumor and adjacent cerebral tissue. The convex areas of thickening were actually projecting into concavities in the surface of the tumor and into adjacent cerebral sulci. RIGHT: Outer surface of bone plaque, to which the overlying dura was loosely attached.

At the time of her transfer to this hospital on April 5, 1971, she was totally bedridden, with a complete hemiplegia and loss of position sense on the left side, a partial autotopagnosia, and a moderate dysarthria. The hemiplegia was flaccid, but there was a left Babinski sign. Left-sided extinction was noted on confrontational visual field testing. There was no papilledema.

Her systolic blood pressure varied from 160 to 220 mm Hg with a diastolic blood pressure consistently below 100 mm. Her electrocardiogram recorded a sinus bradycardia of 45 beats per minute, with evidence of left ventricular systolic overload. The fasting blood sugar on two occasions was 124 and 214 mg/100 ml, with three-hour postprandial blood sugars of 182 and 405 mg/100 ml, respectively. She weighed 86.5 Kg (190 lb) and was 160 cm (5 ft, 3 in) tall.

Her skull films were interpreted as showing hyperostosis frontalis interna, an undisplaced calcified pineal gland, and evidence of calcification in both internal carotid arteries. Technitium-99m rectilinear brain scanning revealed a single focus of abnormal radioactive uptake located peripherally in the right parietal region. An electroencephalogram showed a grade II delta focus in the right fronto-parieto-temporal region. Right retrobrachial and left carotid angiography demonstrated an area of tumor staining in the right fronto-parietal region, measuring about 3 cm in diameter, and lasting almost through the venous phase.

Three days after admission a right fronto-temporo-parietal craniotomy was performed, with grossly complete removal of the tumor in one piece (Fig 1, left). On opening the dura, a somewhat irregular, flat, nodular plaque of subdural ossification was found overlying the tumor surface, and extending partly over the surrounding surface of the brain. The plaque of bone was easily separated from the dura and from the underlying brain and tumor. It broke into two pieces previously joined by a very thin shell (Fig 1, center and right).

Histologically, the tumor was diagnosed as a metastatic, mucous secreting adenocarcinoma of the endometrium (Fig 2, left and center) and its histological pattern was similar to that of the patient's

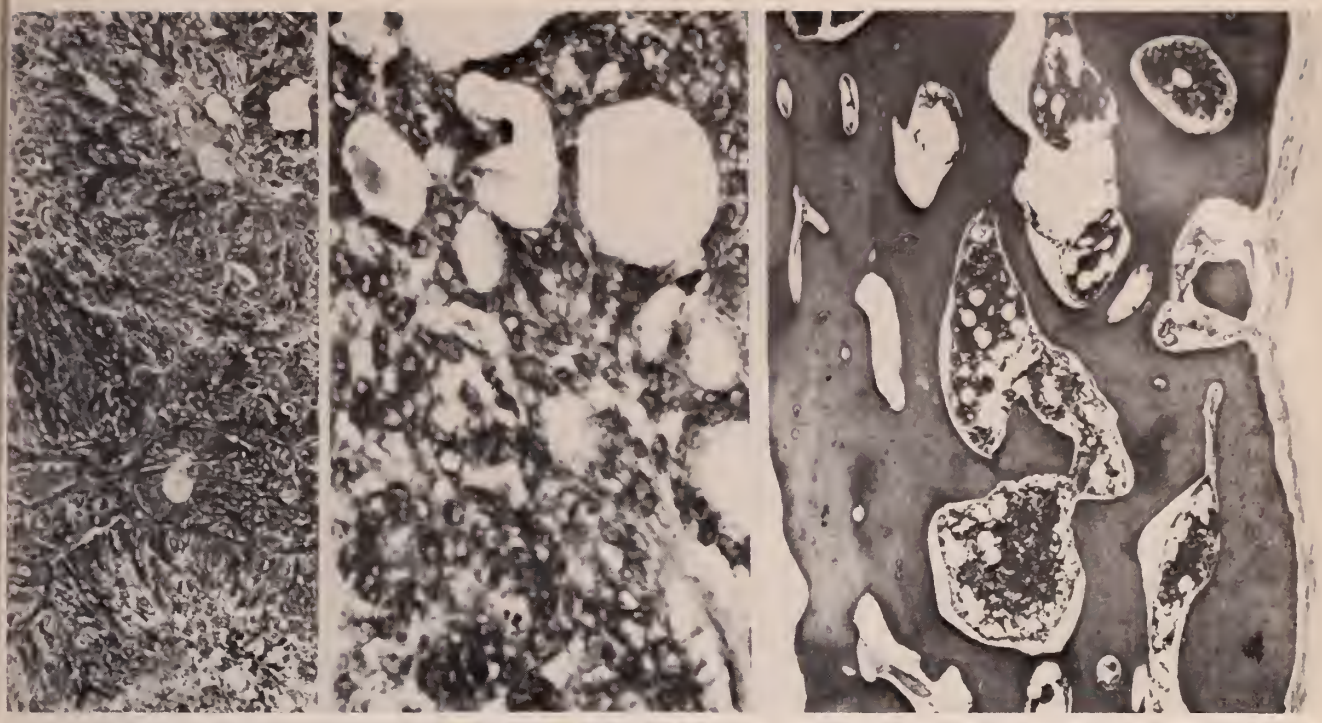

Figure 2—LEFT: Histological section of cerebral tumor, showing the pattern of a mucous secreting endometrial adenocarcinoma. Some of the glandular lumina contained mucin (H&E x100). CENTER: Higher magnification, demonstrating glandular pattern (H&E x400). RIGHT: Histological section of subdural osseous plaque overlying metastatic tumor. Note presence of mature bone and bone marrow, as well as thin layer of attached meningeal tissue on the outer surface (H&E x100).

previously removed endometrial tumor. The subdural osseous plaque consisted of mature bone and bone marrow (Fig 2, right).

Postoperatively, the patient received 5,000 rads of telecobalt irradiation to the entire brain, supplemented with a rehabilitative program of physical and occupational therapy. She was discharged from the hospital on May 20, 1971 with no detectable neurological deficit except for a mild residual dysarthria. This further improved, and the patient became neurologically asymptomatic. She was last seen here, in followup, on Nov. 12, 1971 and was last heard from on May 6, 1972 while vacationing in Florida.

Comment

In 1931 Huggins[1] induced bone formation in the rectus abdominis fascia of experimental animals by placing it in anatomical conjunction with proliferating urinary bladder epithelium. Two factors were considered necessary for this transformation: First, the transforming (or osteogenic) factor in the epithelium of the urinary bladder; and second, the reproducing factor (or ossifying potential) in the affected tissue, which makes its cells competent to undergo the transformation into osteoblasts. The animal host species later proved to be of importance, too, in that epithelial osteogenesis could be induced invariably in the dog and guinea pig,[2] but rather infrequently in rats and rabbits.[3]

Osteogenic activity was found in the mucosa of the urinary bladder, renal pelvis, and ureter[1] and later in the epithelium of the gallbladder[4] and seminal vesicle,[2] but not in the prostate, adrenal cortex or gastric mucosa.[1] The ossifying potential, on the other hand, was demonstrable in the fibroblasts of muscle fascia,[1] knee joint capsule of the dog,[1] and later in the peritoneum and adjacent fibroblasts including omentum;[5] but not in the cells of renal cortex, spleen, liver or in the submucosal fibroblasts of the urinary bladder[5] or gallbladder.[3]

In subsequent studies of osteogenic activity, Urist,[6] Huggins and Urist,[7] and Huggins, Wiseman and Reddi[3] demonstrated that the matrix of decalcified bone, and the matrix of decalcified dentin, contain a powerful osteogenic factor which is resistant to hydrochloric acid and alcohol. This factor appeared to attract enormous numbers of fibroblasts within 24 hours, and rapidly induce a transient chondrogenesis followed by permanent osteogenesis, with a mature bone and bone marrow appearing within 23 days from date of transplantation.

The transformation occurred most consistently when the decalcified dentin of guinea pig, mouse or rat was transplanted into the subcutaneous tissue of the rat; and least of all, when transplanted into the guinea pig. Thus, while the osteogenic factor of bladder epithelium was highly effective in transforming fibroblasts in the guinea pig, and least effective in the rat, the reverse was true for the osteogenic factor of decalcified bone and dentin matrix.

As far as we know, there have been no reports of osteogenic activity induced by normal or neoplastic endometrium in the human or in experimental animals. However, the gross and histological findings in the present case suggest that such activity may indeed be present at least in metastatic mucous secreting endometrial carcinoma. Further studies are contemplated in search of possible osteogenic factors in normal or neoplastic endometrial transplants.

It is also noteworthy that some meningeal cells have the potential for changing into chondroblasts and osteoblasts. Palacios[8] reported a case of intracranial solitary chondroma of dural origin, and reviewed the literature on the subject. Also meningiomas may contain bone, traceable to the periosteal component in the outer layer of the intracranial dura. Huggins et al[5] concluded that one type of fibroblasts has the potential to ossify and another type does not. The ossifying potential of dural and arachnoidal cells is easily demonstrated in the fairly common ossification seen in the falx and arachnoidal granulations[9, 10] as part of the aging process; but the mechanism is not yet fully understood.

Conceivably, our patient's diabetes mellitus may have had some influence on the process of her metaplastic ossification; or the ossification may have been mere coincidence rather than due to the metastatic tumor. However, mature subdural bone plaques are not commonly seen during craniotomies either in diabetic or in non-diabetic patients, and further study of this phenomenon is deemed appropriate.

Summary

A plaque of mature bone and bone marrow was found between the intracranial dura and a cerebral metastatic nodule of mucous secreting endometrial adenocarcinoma. There is ample evidence for the potential of meningeal cells to be transformed into osteoblasts, but we have no knowledge of any osteogenic factors in normal or neoplastic endometrial tissue. Such factors have been reported in other tissues, including urinary tract and seminal vesicle epithelium, gallbladder epithelium, and decalcified bone and dentin matrix. Further studies are contemplated in search of possible osteogenic factors in normal or neoplastic endometrial transplants.

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Marshfield PAs Thrive on Preceptorships

F N LOHRENZ, MD and WILLIAM MATTHEWS, Marshfield Clinic, Marshfield, Wis: *Group Practice* 21: 13–16 (June) 1972

Two years ago two internists at our clinic were each able to care for 20 cancer patients at a time. Today those same two physicians, on the average, provide 30 cancer patients with the same quality of care. What accounts for this 50% increase in productivity? The answer is evident, for only one major factor has been added. The two oncologists now share the services of an RN whom they trained to be a physician's assistant [PA].

She's just one of the 14 PAs working for our clinic now, and they've all proved their worth. Even in a 100-physician clinic like ours there are never enough doctors. The PAs help us make the most of the physician's time by taking on many of the routine tasks that MDs had been performing.

Personal qualities are important in our program because of the close working arrangements between doctor and assistant. Occasionally a PA will train to work with two or several doctors, but usually he is part of a unit with one doctor. By the second year of his training, he is on call for emergencies whenever the doctor who trains him is on call. The doctor is in every sense of the word the assistant's preceptor and is responsible for teaching him everything he should know. The assistant does attend morning clinical conferences, and occasionally more formal classes; but mainly he learns by working with the physician. As a preceptor, the doctor must have patience and an ability to teach, and the assistant needs to be intelligent and must want to learn. More than that is needed, however. The doctor must also be willing to delegate authority to another person, and the assistant must be willing and able to accept responsibility. □

Head and Neurologic Trauma

G. R. BARTL, MD, E. S. GURDJIAN, MD, and L. H. HERMAN, MD
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THE PATIENT WITH significant neurological manifestations will constitute a small but important percentage of any emergency room case load. Accurate and repeated observation of the patient is the keystone of success and adequate written notes are of great importance. The primary examining physician must ascertain if other emergent surgical or medical problems exist; such as, hypovolemic shock, airway obstruction, ruptured abdominal viscus, or hypoadrenal crisis.

Head Trauma

Obtaining the history of any accident from the victim himself helps the examiner in evaluating the mental status of the patient. The examiner should inquire about the nature of the accident, if neck injury occurred in addition to head trauma, if consciousness was lost and for how long a period of time, and if antegrade or retrograde amnesia was present. Those individuals who are able to give a complete account of events and who are oriented to time, place, and person, are obviously in much less immediate danger than those brought in comatose. In the unconscious patient, the above information must be obtained from witnesses and rescue workers.

The scalp must be meticulously examined and wigs removed. Areas of depression should be noted and lacerations sutured after adequate removal of surrounding hair and superficial debridement. Impaled foreign bodies should be noted, but no attempt at removal should be made until their depth of penetration has been ascertained.

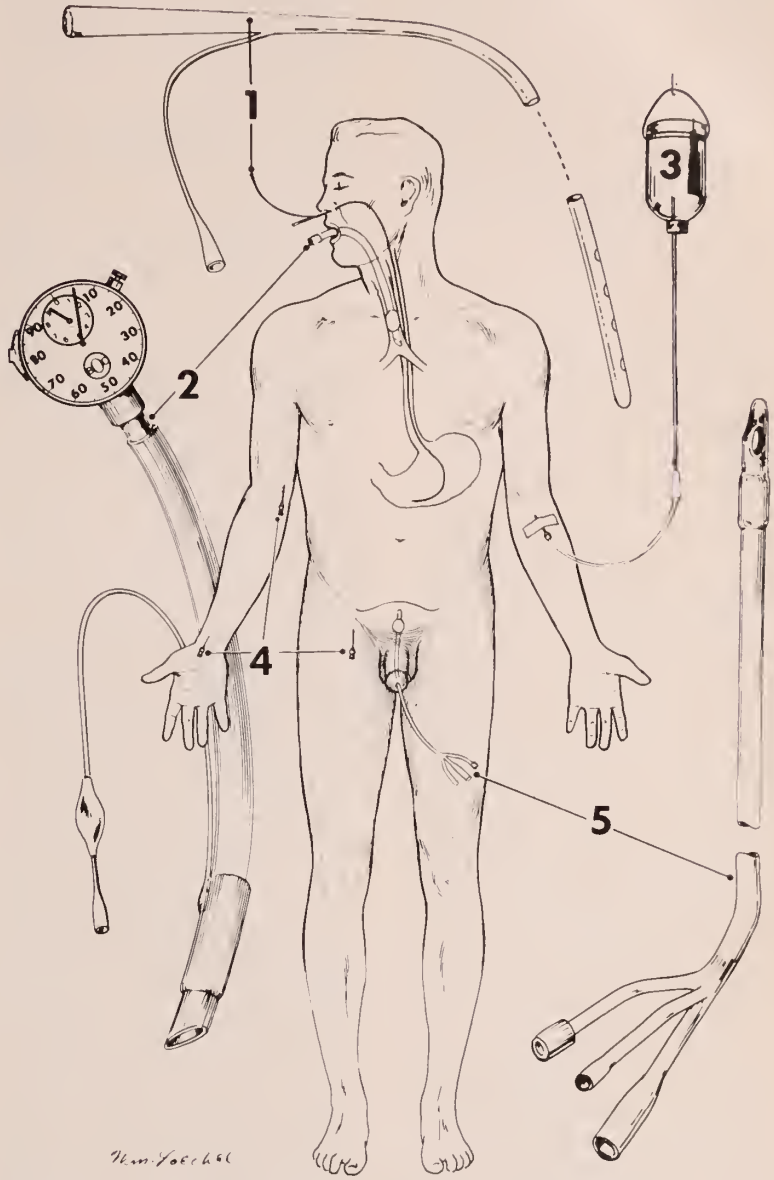

Figure 1—*Pictorial synopsis of emergency room care of the unconscious patient:* [1] Placement of a sump nasogastric tube. [2] Placement of a cuffed endotracheal tube (illustrated with respirometer attached to measure tidal volume). [3] Placement of an intravenous catheter with extension tubing to facilitate administration of fluids, blood, drugs, anesthetic agents, and movement of patient. Withdrawal of blood for complete count, type and crossmatch, electrolytes, alcohol, and barbiturate level can be accomplished while catheter is being placed. [4] Sites from which arterial blood may be obtained for determination of pH, oxygen and carbon dioxide saturation: femoral, brachial and radial arteries. [5] Placement of a three-way Foley catheter to drain urine, obtain specimens for laboratory analysis, facilitate nursing care, and bladder irrigation.

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Those in or through the skull should be left for the neurosurgeon.

The most important observation is the patient's level of conscious state.

In patients fully awake this observation should be made hourly, and in somnolent patients every 15 minutes. Comatose patients should be continuously observed. Any patient exhibiting a trend toward unconsciousness should be seen by a neurosurgeon.

An aid to examining the level of conscious state is the patient's response to pain. A good pinch of the trapezius on either side will reveal the patient's ability to respond and verbalize. In addition, valuable observation of the patient's facial and extremity movements is made.

The second most important observation is the pupillary size and reactivity.

This is particularly important in the somnolent or obtunded patient. The presence of alcohol-like substance on a patient's breath is not sufficient physical evidence for the diagnosis of alcohol intoxication. The change of a reactive pupil to a dilated and sluggishly reactive or nonreactive pupil heralds the need for immediate neurosurgical consultation. The dilated pupil will be on the side of the intracranial pathology in over 90% of cases.

The third observation on head-injured patients should be if the face and limbs are capable of movement.

The patient should be requested to show his teeth, move his arms and legs, and make a fist. Poorly coordinated movements or weakness on one side suggests pathology of the opposite side of the brain.

The fourth observation on head-injured patients should be to note the presence, absence, or asymmetries of the deep tendon reflexes.

Also to be noted is the presence of dorsiflexion of the great toe and fanning of the remaining toes when the plantar aspect of the foot is stimulated—the Babinski reflex. Absent, diminished or pathologic reflexes are usually found opposite the side of cerebral pathology.

The fifth observation on head-injured patients should be the response to touch or pinprick.

Any diminution of response is commonly opposite the side of cerebral pathology.

Treatment

In the patient with a serious head injury, the emergency room physician or nurse should:

(1) Summon a neurosurgeon.

(2) Make an accurate short note on the chart with pertinent observed findings and the time. Note any trends toward improvement or deterioration.

(3) Start intravenous fluids (IV) with a large bore plastic catheter firmly secured to the patient. The addition of a 20-inch extension tubing between the regular IV set and the catheter facilitates the administration of blood and drugs, and makes the nursing care easier.

(4) If the airway is in doubt, a cuffed endotracheal tube should be cautiously inserted, being certain that no injury to the cervical spine occurs. A small device for measuring the tidal volume helps in determining if the patient will need respiratory assistance.

(5) Blood should be drawn for complete blood count (CBC), type and crossmatch of four units of blood, electrolytes, oxygen (O_2), carbon dioxide (CO_2), alcohol, and barbiturate levels. Frequently this specimen can be obtained when the IV catheter is placed. Arterial pH, O_2, and CO_2 may also need to be determined.

(6) An indwelling urinary bladder catheter should be placed and a urine specimen obtained. The three-way Foley catheter is a superior catheter as it allows for subsequent irrigation of the bladder. The catheter should be taped to the thigh to prevent its inadvertent avulsion during subsequent patient movements.

(7) Appropriate x-ray films should be taken of the skull, cervical spine, and chest. Additional films should be obtained as indicated. Cervical spine injuries may go unsuspected in the head-injured patient only to manifest themselves when the patient is moved at some later time. The chest x-ray film will indicate if the endotracheal tube is correctly placed, if aspiration pneumonia is present, or if pulmonary contusion is present.

(8) If cerebral tissue is exposed, the area around it should be carefully shaved and sterile sponges moistened with sterile saline placed over the exposed brain and a bulky dressing applied.

(9) A nasogastric tube should be inserted and the stomach emptied. A sump type Levin tube tends to plug less frequently than the ordinary variety.

(10) Intravenous fluid should be given sparingly if the patient is not in shock or dehydrated. Too much fluid can only potentiate any existing cerebral swelling. If the skin has been broken, tetanus toxoid should be given. Steroids in generous doses in the brain-injured patient are indicated. Ten mg of dexamethasone (Decadron®) or 60 mg of hydrocortisone (Solu-Cortef®) given IV may be helpful in preventing intracellular edema and combating the fatigue phase of the General Adaptation Syndrome. In open wounds of the brain and when cerebrospinal fluid (CSF) leakage from the ear or nose is suspected adequate doses of penicillin or ampicillin should be given. In the infected case, after suitable cultures and sensitivities are obtained, the therapy can be appropriately altered as necessary.

(11) The timing and use of osmotic diuretics should be left to the discretion of the neurosurgeon. The use of osmotic diuretics may permit time for getting the patient ready for surgical in-

tervention. One gram of mannitol per pound of body weight should be given intravenously over a 30-minute period. It is important to remember that continued use of these agents has not been worthwhile in the management of the seriously ill patient with head injury or with a space occupying mass lesion.

(12) Cerebral angiography should be performed by the physician skilled in its use. Not only because of the lowered morbidity and mortality in his hands but also because the interpretation of films may present some problems to the inexperienced.

(13) Diagnostic lumbar puncture may be indicated to rule out infection or subarachnoid hemorrhage. Patients who receive a lumbar puncture should be hospitalized at least overnight. Lumbar puncture has been of little help in the diagnosis of mass lesions in the acute head-injured patient and may be dangerous in those patients who harbor an acute subdural or epidural hematoma. The release of cerebrospinal fluid from the lumbar sac combined with a supratentorial mass lesion may cause uncal and cerebello-medullary herniation leading to respiratory and cardiac arrest and death.

The above emergency room procedures not only expedite the diagnosis of intracranial lesions but also significantly contribute to the lowering of morbidity and mortality by cutting down on the time between diagnosis and surgery and in the prevention of complications before they arise.

Neck Injuries

Those individuals thought by history or physical examination to be suffering from a spine injury should be kept in the recumbent supine position with the neck immobilized by sand bags. The patient should be accompanied by a physician or a nurse during any necessary travels from the emergency room and preferably not moved at all until a definitive diagnosis is made and emergency treatment instituted.

All patients that present with a history of trauma and a stiff or painful neck or back are suspect. Rarely, no history of trauma significant to the patient may be elicited. Most commonly a neurologic deficit is present on admission.

The physical examination should be gentle and no initial attempt made to reposition the neck or back. It should be noted if the head is held "cocked" to one side or if the patient only moves the head or back in certain planes. The thoracic and lumbar spine may exhibit a deformity with gibbus, loss of normal lumbar lordosis, or localized tenderness. A skin contusion or laceration may be present overlying the spinal injury.

The motor system is checked as in the head-injured patient. The examiner may notice lack of movement of both lower extremities. Commonly some impairment of both upper extremities as well may occur.

An attempt to determine the lowest level of intact neurologic function should be made. Observation should be made of the patient's respirations and the tone of his anal sphincter.

Reflexes are next checked. Decreased or absent deep tendon reflexes may help to localize the level involved. The reflexes of the lower limbs should be compared with those of the upper limbs. A search should be made for the superficial abdominal reflexes and the cremasteric reflex in males. Priapism may be present and is due to the reflex engorgement of the bulbus cavernosus and corpora cavernosa.

The sensory level should next be ascertained. Certain rough estimates can be made and any tendency toward raising or lowering of a sensory level should be noted. It may be helpful to place a mark on the patient at the lowest level of sensation with the time appropriately noted. It is important to note the modalities of touch and proprioception as well as pinprick and temperature. Any apparent discrepancies may be highly localizing.

Treatment

(1) The initial treatment of suspected fractures of the cervical spine with or without neurologic deficit consists of immobilization of the neck by sand bags or other devices to prevent motion.

(2) Adequate cervical spine x-ray films must then be obtained. The physician or nurse should accompany the patient to the x-ray department to guard against over-zealous movement of the patient by the technician in attempts to get good films. Frequently the physician's aid will be needed in pulling the shoulders down to visualize the lower cervical vertebrae (Fig 2). A swimmer's view will occasionally be necessary to adequately visualize the lower cervical spine. A chest x-ray film may help to determine diaphragmatic movement.

(3) Intravenous fluids should be started in most patients with the diagnosis of fracture of the cervical spine. Immobilization may cause an ileus necessitating the restriction of oral intake. The quadra- or paraplegic patient is given nothing by mouth for they are most certain to have an initial 2 to 3 day period of ileus. Intake and output should be determined and recorded.

(4) The nasogastric sump tube is placed in all patients in whom bowel sounds cannot be heard. This early drainage not only prevents a possible gastric dilatation and atony but also distention of the abdomen with subsequent elevation of the diaphragm and possible compromise of an already borderline tidal volume.

(5) Tidal volume should be determined in the emergency room. Tracheostomy, cuffed tracheostomy tube, and positive pressure respiratory assist are indicated for those patients with a reduced tidal volume. In those

patients who are borderline, early tracheostomy is indicated. As most patients with cervical spine injuries are alert, no attempt should be made to pass an oral endotracheal tube. The patient will fight any attempts and further progression of neurologic deficit may occur.

(6) In the neurologically intact patient a condom or Texas® catheter may facilitate the nursing care. In those patients with an involvement of the spinal cord a three-way urinary Foley catheter should be placed as early as possible. Bladder decompensation from distention occurs within hours. In those patients with priapism the Foley catheter should obviously be taped to the abdomen and not to the thigh.

(7) The patient should be placed on a Stryker frame or circle bed. Appropriate attachments for cervical traction should be nearby and available. Instruments for the placement of Crutchfield or Vinke tongs should be sterile. The patient should be in skeletal traction before leaving the emergency room although the tongs themselves should be applied by a neurosurgeon, an orthopedist, or one skilled in their insertion. Tongs poorly placed or loose may come out later with potentially disastrous results.

(8) Elastic bandages placed on the lower extremities to prevent edema are mentioned only to be condemned. The authors have seen gangrenous limbs amputated following their use.

(9) Although a patient deprived of sensation from the neck down has no pain from limb ischemia, bladder distention, or skin breakdown, he may need some tranquilization as the inability to move and the magnitude of his predicament dawns upon him. Tranquilizers in adequate doses have been a useful adjunct in management.

(10) If lumbar puncture is deemed advisable, it should be done only after adequate immobilization by traction. At the time of lumbar puncture a Queckenstedt test should be performed. In the presence of a block, myelography may be desirable. Six to 10 ml of iophendylate (Pantopaque®) is instilled and the needle removed. The

Figure 2—*Lateral x-ray films of cervical spine.* The view on the left was taken with the shoulders pulled down and reveals a fracture dislocation involving the fifth and sixth cervical vertebrae. The view on the right is of the same patient, taken earlier without the shoulders pulled down, and does not reveal the fracture dislocation.

patient should undergo fluoroscopy and the level of block ascertained. Surgical intervention may then follow.

Early diagnosis and treatment of spinal cord injuries in the emergency room are aimed at preventing the patient from suffering any progression of his neurologic deficit due to faulty manipulations and movements of the head, neck and body. The prognosis for the recovery of lost functions may be difficult to ascertain early. Concussive lesions, however, may improve in minutes to hours.

Peripheral Nerve Injuries

Patients seen in the emergency room with suspected peripheral nerve injuries frequently have other associated injuries. There may be a clavicular or other long bone fractures or contusion and/or laceration of an extremity. Most commonly there will be a laceration, puncture wound, or gunshot wound.

In the unconscious patient, lacerations on the lateral aspect of the face may involve the main trunk of the facial nerve or the branches of the pes anserinus.

Nerve injuries of the upper extremity may be suspected when lacerations are seen on the volar surface of the wrist (median and ulnar nerves), about the epicondylar groove (ulnar nerve), and on the lateral and posterior aspect of the arm (radial nerve).

The radial nerve can be tested by asking the patient to extend his arm at the elbow, to extend his hand at the wrist, and to extend his fingers. The musculocutaneous nerve can be tested by asking the patient to flex his bicep. The median nerve can be tested by asking the patient to flex his fingers and wrist. The ulnar nerve may be tested by asking the patient to ad- and abduct his fingers and to adduct his thumb. Loss of sensation in the medial one and one-half fingers indicates ulnar nerve involvement. Loss of sensation in the lateral three and one-half fingers indicates median nerve involvement and loss of sensation on the dorsum of the hand between the thumb and index finger indicates radial nerve involvement.

Nerve injuries in the lower extremities may be suspected by injuries with a laceration of the groin (femoral nerve), of the posterior thigh (sciatic nerve), of the popliteal fossa (sciatic and tibial nerves), in the lateral aspect of the knee joint (peroneal nerve). Weakness of the quadriceps suggests femoral involvement. Inability to evert and elevate the foot suggests peroneal involvement and inability to plantar flex the foot suggests tibial involvement. Sensory loss of the lateral leg, dorsum of the foot and toes is due to peroneal involvement. Sensory loss of the sole of the foot and plantar aspect of the toes is due to tibial involvement.

In those patients who have closed injuries, a carefully recorded neurologic examination including motor and sensory changes combined with appropriate treatment for any other conditions present is satisfactory. The patient should be referred to a neurosurgeon for treatment and followup evaluation.

In patients with closed fractures of the long bones the extent of the neurologic deficit if present is recorded and appropriate treatment of the fractures performed by the orthopedist. These recorded observations, in addition, may later have medicolegal significance.

When open fractures with neurologic deficit are encountered, the wound should be covered

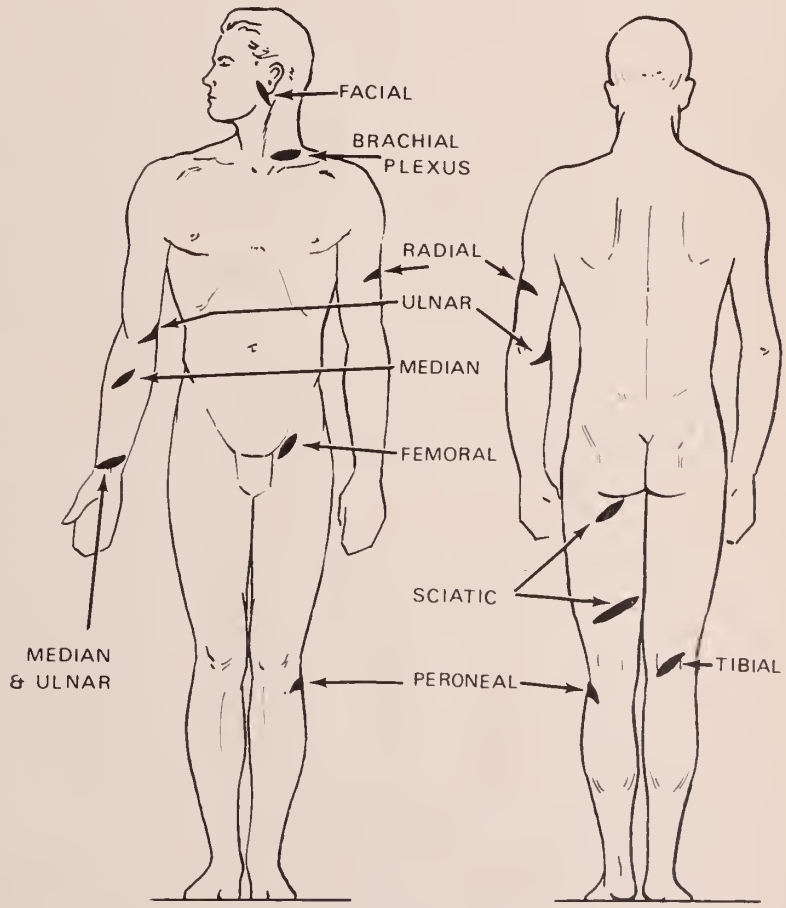

Figure 3—*Location of lacerations which may be accompanied by peripheral nerve injuries.*

with sterile dressings moistened with normal saline and the extremity placed in the appropriate splint. After careful recording of the extent of neurologic deficit the orthopedist and neurosurgeon should be notified. They may wish to operate on such a patient together. Evaluation of the anatomical continuity of the nerve can best be made at surgery.

The patient with a deep laceration which involves a major nerve may also present lacerations of tendons, especially the volar aspect of the forearm. If tendons are involved, the extent of the involvement should be recorded. In this manner an appropriate search will be conducted to find and repair the involved tendon at surgery.

Extensive wounds of the forearm further compounded by the retraction of tissue, dirt in the wound, inadequate anesthesia, and light in the ill-equipped emergency facility, are best treated in the operating room. Thus useful recorded observations, tying off of active bleeders, application of sterile dressings, and appropriate analgesia to relieve pain are sufficient emergency room care.

In the clean laceration in which the structures are clearly defined, primary repair may be attempted after freshening the nerve edges. A silicone cuff sized and placed over the nerve before the repair is started and then positioned over the anastomosis will retard invasion of the anastomotic site by fibroblasts. The patient must then be followed often for months before assessing the success of the surgery. □

MEDICAL SCENE IN WISCONSIN

Radiologic Technique to Diagnose Osteoporosis Perfected at UW–Madison

Radiologists at University Hospitals can now perform a routine evaluation of the mineral content of bones to determine if an individual has osteoporosis or thin bones.

"Loss of bone mineral is almost universal with age," explained Mark Mueller, MD, rheumatologist at University Hospitals, "but the problem is particularly severe in women."

"Approximately 150,000–200,000 women in the United States suffer hip fractures yearly because they are osteoporotic," said Mueller. "This procedure can detect bone demineralization before fractures occur so that treatment can be begun and evaluated with the aim of reversing the process."

The procedure, developed by John Cameron, PhD, UW medical physicist, is the most accurate measure of bone mineral content short of excising bone, ashing it, and weighing it.

"We developed this technique in response to a need expressed by physicians," explained Doctor Cameron. "Bone changes occur very slowly, and there was no good way to measure minor changes in bone mineral content," he said. "We began developing this technique in 1960, and today it is being used at numerous medical centers throughout the world."

"We've tested the technique on thousands of persons and found it amazingly accurate, to within one or two percent. It's a classic example of the application of basic science research to clinical needs," said Doctor Cameron.

The technique is based on a photon absorptiometric method which involves scanning the bone with gamma rays. A collimated detector measures the scanning and feeds the information into a computer. The computer calculates the bone mineral per unit length and width of the bone from the resulting absorption curve. The results give two figures: bone mineral content and bone width.

"The test is painless and takes approximately 10 minutes," said Doctor Mueller. "There is no significant danger of radiation; the amount used is much less than a standard x-ray. The test enables us to evaluate various treatment methods since it allows us to detect even minor changes in bone mineral content."

Patients can be referred to University Hospitals for the diagnostic procedure, and the referring physician will receive a report of the bone width and mineral content, as well as a normal value for patients of a comparable age.

In cases where a patient has significant bone mineral loss, a letter of diagnosis and interpretation will accompany the test results which are sent to the physician.

Patients with medical problems appropriate for this analysis would be post-menopausal women and patients of either sex with endocrinopathies, malabsorption, malignancies, significant renal disease, arthritis or other locomotor disabilities. It could also be useful for patients who are either on corticosteroids or are going to be treated in the future with corticosteroids, as well as patients with diseases which lead to hypercatabolic states, inadequate nutrition or reduced physical activity. □

A Collection of Abstracts on Clinical Dermatology

The many facets of clinical dermatology were well depicted by the papers published in the Cutis *magazine, September 1972 issue, as part of a special issue on the University of Wisconsin. Guest editor was Sture A. M. Johnson, MD who served as chairman of the University's Department of Dermatology from 1946–1972. The abstracts follow.*

Calcinosis Cutis

STURE A M JOHNSON, MD, Madison, Wis: *Cutis* 10:275–278 (Sept) 1972

The various diseases or conditions associated with calcification were discussed and outlined along with theories which have been proposed to account for the changes. The author divided illnesses associated with calcification into two major groups like the metabolic normocalcemic type of which calcinosis circumscripta, calcinosis universalis and the localized are examples, and the metastatic hypercalcemic type. X-rays were presented showing the type of calcification which may occur in the three types of normocalcemic calcinosis. Therapy for calcification was briefly outlined.

Familial Cutaneous Collagenoma

STEPHEN I HEGEDUS, MD and WILLIAM F SCHORR, MD, Madison and Marshfield, Wis respectively: *Cutis* 10:283–288 (Sept) 1972

The authors presented a case of cutaneous collagenoma with clinical and histologic findings. The entity was characterized by numerous rubbery, skin colored asymptomatic cutaneous nodules with marked predilection on the upper two thirds of the body. Histiologically there is great increase in collagen extending down below the deepest sweat glands. The elastic tissue is decreased and can be absent in some areas. Other connective tissue nevi were discussed and there was a useful table to differentiate them.

Perioral Dermatitis (Mihan and Ayres)

STEPHAN EPSTEIN, MD, Madison, Wis: *Cutis* 10: 317–321 (Sept) 1972

In this paper the author reported three women with the disorder and reviewed the literature. In one patient stopping a contraceptive hormone gave complete resolution. In the other two response was obtained with adequate amounts of tetracycline, although one patient noted provocation on exposure to sun. The eruption is characterized by a papular and at times eczematous scaly eruption which affects the perioral areas, especially the chin, nasolabial folds, and upper lip. There is often a clear zone around the vermillion borders of the lip. The eruption pursues a fluctuating course. The author stressed that tetracycline in adequate amounts derives dramatic and quick results in suppressing the symptoms, but therapy may have to be continued for years.

Verrucae Vulgarius Involving a Leg with Lymphedema: Therapy with Podophyllin

DONALD J MIELKE, MD and STURE A M JOHNSON, MD, Madison, Wis: *Cutis* 10:352–353 (Sept) 1972

The authors presented a 48-year-old white patient with lymphedema of the one leg that had been present since nine months of age. Three months before hospitalization the patient had developed verrucae vulgaris which practically covered all of the skin surface of the limb. After several forms of treatment had been used and proved to be unsuccessful, 25% podophyllin in tincture of benzoin compound was employed and with this clearing of the skin occurred. The resolution of the lesions was felt to be due to the fact that moisture of the skin caused by the edema made the podophyllin behave as it would in treating condylomata accuminata.

Primary Irritant Dermatitis: Caused by pHisoHex®

THOMAS L WATT, MD and ROBERT R BAUMANN, MD, Monroe, Wis: *Cutis* 10:363–364 (Sept) 1972

A 13-year-old white girl who started using pHisoHex® as treatment for early acne vulgaris developed a band of erythema along her hairline, periphery of cheek and sides of the neck. The eruption disappeared upon discontinuation of pHisoHex® only to recur on reuse. Dial soap, which also contains hexachlorophene like pHisoHex®, did not cause a reaction. The difference was felt to be due to the greater solubility of the hexachlorophene in a bar of soap. Patch tests were negative and photo testing was not done.

Acne Vulgaris: Treatment with Three Newer Antibiotics

HUBERT V MOSS, MD, Madison, Wis: *Cutis* 10:375–376 (Sept) 1972

In this study clindamycin *(Cleocin®)*, lincomycin *(Lincocin®)*, and doxycycline *(Vibramycin®)* were used in the treatment of various stages of acne vulgaris. Good to excellent results were obtained with clindamycin (43%), lincomycin (46%), and doxycycline (41%). This compares favorably with tetracycline (42%). Side effects, such as loose stools and abdominal cramps, were most noticeably seen with lincomycin. □

Evaluation of Pericardial Effusion Using Photoscintigraphic Technique

GEORGE DRASIN, MD, MARY STEIN, ROSALIE HOVEY, and IAN TYSON, MD
Madison, Wisconsin

THE CONVALESCENCE from uncomplicated myocardial infarction is generally uneventful. Occasionally it is marred by the onset of pericardial effusion. When these effusions are large, little clinical difficulty is encountered in the diagnosis of their presence. However the presence of a pericardial friction rub followed by its disappearance without concomitant improvement in the patient may signal the onset of a small but significant effusion. Therefore it appears desirable to attempt to establish the presence of pericardial effusions by a non-invasive technique. Various investigators have demonstrated the presence of a pericardial effusion by the technique of heart scanning using either a rectilinear scanner or a scintillation camera.[1,2] Demonstration of pericardial effusion using the relatively non-invasive technique of angiophotoscintigraphy with the injection of radionuclide and a scintillation camera has revived substantial interest in this technique for three reasons: (1) minimal discomfort to the patient, (2) relatively non-invasive technique, and (3) the relatively widespread use of the scintillation camera in hospitals having less than 200 beds.

From the Section of Nuclear Medicine, Department of Radiology, University of Wisconsin Center for Health Sciences, Madison.

Study carried out during Nuclear Medicine rotation as part of Doctor Drasin's Radiology residency.

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Figure 1—Cardiac angiophotoscintigram initial study and chest x-ray film compared: [A] 3.0 sec exposure from flow study; [B] the steady-state 1.0 min image. Anterior view (note bar of radioactivity extending vertically downward consistent with aortic flow); and [C] the chest x-ray film on the same day.

Figure 1B

Figure 1C

It appears important then that some clear criteria be set down by which the diagnosis may be most readily established in the highest number of instances so that the most benefit from this procedure may be obtained. This case report reviews our current procedure and considers the current status of the value of the test.

Method

Patients are brought to the Nuclear Medicine Service in their intensive care bed together with all monitoring devices. The patient lies under the scintillation camera head at an angle of 30 degrees to the horizontal supported by a wooden bed board under the mattress. The anterior chest wall at the level of the xiphoid is placed halfway between the lowest circumferential point and the center of the collimator face. Studies have been carried out either with a scintillation camera or a rectilinear scanner, the camera being tuned to produce maximum uniformity rather than for absolute maximum resolution. A high resolution low energy collimator was used.

Intravenous injections of freshly prepared sodium pertechnetate were made from a sterile closed ^{99m}Tc generator in doses of 5–10 mC. Images were photographed at 1–3 second intervals rapid sequence and subsequently at 1.0 minute intervals steady state. The diagnosis has been clearly established when the following criteria are met:

(1) During the cardiac angiophotoscintigraphy (rapid sequence). A complete encircling ring appears around the cardiac blood pool and separating it from the pulmonary blood pool.

(2) This clear ring persists during the later steady-state pictures separating the cardiac blood pools from the pulmonary blood pools, the liver and the stomach area.

(3) The presence of a clearly defined bar of activity, corresponding to the aortic blood flow in the early angiographic phase, is helpful when present.

No quantitative comparison is made of the value of x-ray, the cardiac angiophotoscintigraphic and the ultrasound technique for the detection of pericardial effusions.

Case Report

A 64-year-old white male plumber developed sudden chest pain on Nov. 27, 1971 and was hospitalized. Electrocardiograms were interpreted as showing an inferior wall infarct, atrial fibrillation, a ventricular rate of 40–60 and subsequent complete heart block. The initial blood pressure was 142/84 mm Hg but this rapidly dropped to 80/60 necessitating isoproterenol hydrochloride drip followed by transvenous pacemaker implantation and digitalization. The central venous pressure (CVP) and blood pressure improved. On Nov. 30, 1971 the CVP was 17 to 19 and basilar râles in the chest were noted. By Dec. 4, 1971 the cardiac rate had stabilized and the pacemaker was removed. On the next day atrial fibrillation was noted. The patient became fatigued and furosemide was given because of a developing congestive heart failure (CHF). Two days later he developed a diastolic murmur and pericardial friction rub. By Dec. 13, 1971 fluoroscopy showed dampened cardiac impulses but no visible moving fat pad to identify a pericardial effusion, but on Dec. 14, 1971 heart scan showed huge pericardial effusion. Eight hundred ml of fluid was removed by pericardicentesis and the CVP dropped from 19 to 13 immediately. By Dec. 15, 1971 pericardial friction rub and S_4 had disappeared. Heart scan showed persistent but smaller effusion. On Dec. 16, 1971 repeat tap removed 225 ml. The patient slowly improved and was transferred to a rest home later. Five mC doses of ^{99m}Tc as $Na[^{99m}TcO_4]$ and a scintillation camera were used for each test.

Commentary

The completed ring of absent radioactivity surrounding the cardiac blood pool remained complete during the early cardioangiographic phase as well as in the steady-state situation both in the initial and the followup study (Figs 1a,b and 2a,b). Secondly, comparison of the initial and followup study shows that there is very poor quantitation between the width and extent of the ring of low activity surrounding the cardiac pool related to the volume of the effusion.

In review of our experience with this technique, we have carried out 64 studies since 1967. Of those, we have successfully demonstrated pericardial effusions in 62. In none of these cases have we been able to estimate accurately the volume of the effusion. With regard to the two cases in which effusions were not demonstrated by this technique, only one occurred recently. One instance turned out to be a 0.5 cm thick pericardium with minimal additional fluid. In both instances, however, the areas of reduced uptakes around the cardiac blood pool were partial. Another factor in the establishment of the diagnosis of pericardial effusion by cardiac angiophotoscintigraphy is the demonstration of a bar of radioactivity corresponding to the aorta and the inferior vena cava. This activity when seen both in the initial and the steady-state studies is helpful.

By comparison with other diagnostic techniques heart scan (rectillinear scanner) or cardiac angiophotoscintigram (camera study) appears reliable and accurate when hemodynamically important pericardial effusions are present.

[A]

Figure 2—Followup cardiac angiophotoscintigram after removal of 800 ml of fluid by pericardicentesis. [A] 3.0 sec exposure from flow study; [B] the steady-state 1.0 min exposure. The vertical bar of radioactivity while still present is only poorly seen.

[B]

TABLE 1—*Comparison of nuclear medicine procedure and other techniques*

Patients	Procedures	Diagnosis Confirmed by		Ultrasound	Overall Other Techniques
		Autopsy	Fluid Withdrawal		
5 (1 false negative)	5 (20%)†	4* (80%)			
15 (1 false negative)	15		14* (93%)		
9 (3 false positives by ultrasound)	9			6	
61 (2 false negatives)	65 (3.0%)†				63 (97%)
(1 false positive)	(1.0%)				

Improvement of diagnostic accuracy by rigid application of criteria outlined in this report. Eight instances in series: 12.5%.
*Includes one case where the pericardium had an average thickness of 0.5 cm in addition to a small amount of excess fluid.
†Includes one early study by a technique now abandoned.

As can be seen from Table 1, ultrasound gave rise to three false positives in nine attempts, a surprising but scanty set of data in light of other studies.[3]

On retrospective review little change in the diagnosis of the presence of pericardial effusion by radionuclide procedure was noted by the present authors compared to the initial reports in the patient's charts when the principles outlined were strictly adhered to.

Transmission scan techniques on occasion have been used to confirm the presence of effusion, but because (a) the total time for the study is less than two minutes and (b) the high diffusion rate of $^{99m}TcO_4$ into the effusion fluid has not introduced any interpretive difficulty, the technique (transmission scan), although extremely useful when available, is not considered essential.

The disappearing "donut sign" described by Holmes et al[4] and noted when studies are carried out in the left anterior oblique position was not evaluated in this series. The value of this sign must be considered in the light of diffusion of $^{99m}TcO_4$ in the overlying extracellular fluid which may rapidly increase the countrate of the overlying lateral chest wall, due to greater muscle and/or fat. With the use of the anterior view and a 90-second study period little difficulty has occurred.

It is concluded that the heart scan or cardiac angiophotoscintigram is simple, reliable, and readily performed with relatively minimal patient discomfort. However, no qualitative estimate of the effusion volume has been possible as indicated by comparison of Figures 1 and 2 which are not significantly different.

Summary

The technique of cardioangiophotoscintigraphy is of significant value in the demonstration of pericardial effusion when (1) there is a clear area of reduced activity surrounding the cardiac blood pool, (2) the clear halo around the cardiac blood pool persists in the steady-state photoscintigram period of the study, and (3) a bar of activity corresponding to the aortic blood flow is present in the early angiographic phase. The major advantage of the technique is its relative non-invasiveness, its rapidity, and the fact that the patient can be studied at bedside if necessary.

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Clinical Survey of Pigeon Breeders

JORDAN N FINK, MD, DONALD P SCHLUETER, MD, ABE J SOSMAN, MD, GEORGE F UNGER, MD, JOSEPH J BARBORIAK, PhD, ALFRED A. RIMM, PhD, JOHN A ARKINS, MD, and KULWANT S DHALIWAL, MD, VA Hospital, Milwaukee, Wis: *Chest* 62:277–281 (Sept) 1972

Two hundred pigeon breeders attending a national convention were studied for a possible correlation between the hobby of raising pigeons and the incidence of respiratory or immunological abnormalities. Information concerning his exposure to pigeons, respiratory symptoms and smoking habits was obtained from each breeder. Chest x-ray examinations and pulmonary function tests also were obtained, and sera were examined for the presence of precipitating antibody against pigeon antigens.

Precipitating antibody was detected in 40 percent of the breeders, and its presence could not be correlated with any of the variables, except with the duration and degree of exposure to birds. No cases of pigeon breeders' disease were detected, and there was no correlation between respiratory symptoms, abnormal pulmonary functions or chest x-ray films, and degree of exposure to pigeons.

These results suggest that the tested group of pigeon breeders probably did not significantly differ from the general population except for the presence of precipitins against pigeon antigens. □

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